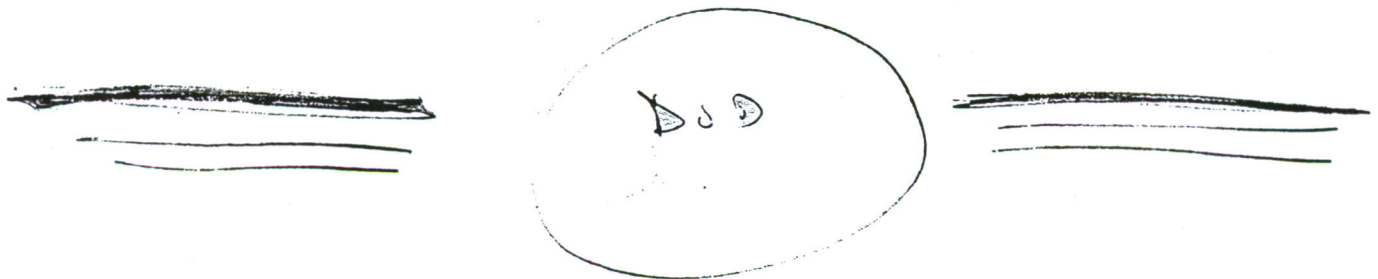


**INTEGRATED CONUS
MEDICAL MOBILIZATION
PLAN: EXECUTIVE
SUMMARY**

DOD XXXX. VXP

DEPARTMENT OF DEFENSE



Army

NAVY

AF

MC

INTEGRATED CONUS MEDICAL MOBILIZATION PLAN

EXECUTIVE SUMMARY

ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)

September 1987

September 1987

FOREWORD

In the Spring of 1985, the Military Construction Subcommittees of both Houses of Congress asked that I develop an integrated plan for CONUS medical mobilization. The thrust of the request was for the Department to be able to identify, in priority, which medical facilities need replacement, repair or modification; and second, to be able to specify the size these facilities should be.

In actuality, I already had two initiatives in progress which would answer those Congressional concerns:

- * A Task Force implementing the recommendations of the Blue Ribbon Panel on sizing DoD Medical Treatment Facilities. One recommendation was that I review and select construction projects recommended by the Services for funding. To accomplish this review I established the Defense Medical Facilities Office.

- * Second, I am developing, with the Services, a medical force sizing methodology incorporating medical readiness as a foundation for the size of the DoD medical system. This methodology would provide for sizing DoD medical treatment facilities.

A CONUS medical mobilization plan, integrating the requirements and capabilities of each of the Services, should address more than facilities alone. The integration process should highlight the policies, philosophies, procedures and responsibilities inherent in mobilization activities. We know that across the Services, policies and procedures differ, that little sharing of resources occurs, and that dependence upon the Veterans Administration and civil sector has become a significant planning factor for each Service. Essentially, there are three medical departments operating, each attempting to take care of its own, and competing with one another for the available manpower, materiel, and money.

In December 1985, I briefed the Secretary of Defense that an integrated CONUS medical mobilization plan would be developed as a major section of the Medical Readiness Strategic Plan. The Secretary approved the initiative and in May 1986 a dedicated Task Force began work on the CONUS plan.

The Integrated CONUS Medical Mobilization Plan has been written to be an evolving plan, one which will be changed and improved as policies and procedures of the Department change.

William Mayer, M.D.

EXECUTIVE SUMMARY

A. BACKGROUND

1. The idea for an integrated medical mobilization plan for the United States began in 1985 at the Military Construction subcommittee hearings in both Houses of Congress. The reasoning for the plan was modified, indeed expanded, by the Assistant Secretary of Defense for Health Affairs. In his March 25, 1986, Memorandum, the Assistant Secretary stated:

"There has been little coordination among the Services to determine utilization of facilities, installations, personnel and equipment; timing, location and anticipated numbers of mobilizing forces; and plans for casualty distribution. Today, we cannot identify, in priority, which facilities require renovation or rebuilding based upon their mobilization/wartime missions."

2. From the March 25, 1986, Memorandum, the scope of the plan was drawn; it would include all resources, not just facilities, and it would address the major mobilization activities: mobilizing Reserve Component personnel and units, training, and care for returning casualties.

3. The plan was written by a joint service task force comprised of representatives of each Military Department, a member of the Army Reserve, and a representative from the Office of the Assistant Secretary of Defense for Health Affairs. The

Task Force, under the direction of the Deputy Assistant Secretary of Defense (Medical Readiness), received advice and guidance from a DoD Advisory Committee. Composition of the Advisory Committee included representatives from each Military Department, the Marine Corps, the Organization of the Joint Chiefs of Staff, and the Offices of the Assistant Secretaries of Defense for Health Affairs, Reserve Affairs and Force Management and Personnel. Members of the Task Force were:

Mrs. Marianne K. Coates, OASD(HA)(MR)

LTCOL Harvey R. Lettofsky, MSC, USAF

CDR William A. Joseph, MSC, USN

MAJ Anthony D. Stem, MSC, USAR

MAJ Earl S. Newsome, MSC, USA

MAJ Thomas Murphy, MSC, USA

4. The Task Force began its work on May 5, 1986, and completed the first draft plan on November 6, 1986. By mid-December 1986, each of the Military Departments had expressed concern with the command and control structure described in the draft plan.

5. The DASD(MR) worked with the Military Departments and Marine Corps representatives to find a mutually acceptable alternative to the command and control structure. Agreement was not reached. Options for command and control were briefed to the Assistant Secretary of Defense for Health Affairs on February 24, 1987. The command and control structure described

in the plan represents the decision made by the Assistant Secretary.

B. SCOPE

1. The initial thought for an integrated CONUS medical mobilization plan centered on military facility construction and modification. However, such a plan could not be written without giving equal consideration to personnel, logistics, other federal resources and the civil sector. These categories of resources all play roles in any mobilization scenario. The degree of activity, however, is based on the level of mobilization.

2. Each level of mobilization carries its own authorities and required actions. These levels are briefly discussed in Chapter III, Annex A. The Task Force focused on full mobilization with conflict, since at that level all programs, systems, and plans are activated. At full mobilization, the health care systems and their resources in CONUS would be severely strained.

3. During a full mobilization, major activities occur independently, yet simultaneously. Three of these activities create a significant demand upon the military health service system in the United States. The three activities are: activation of the Reserve Component, training and transition, and treatment and return to duty of casualties. The Task Force examined the health service impacts of these three activities considering requirements, capabilities and discrepancies.

4. Finally, the Task Force evaluated current plans, policies and procedures to determine how best they might be integrated to assist the Department in satisfying its medical mobilization mission.

C. APPROACH

1. The Task Force approached integration of the military health care resources in the Continental United States (CONUS) in two ways: an organizational plan and a collective perspective. In the first instance, there are three separate military health care systems functioning in the United States, all accomplishing similar missions. No attempts have been made to jointly examine residual resources, to re-evaluate missions, or to consolidate to improve capabilities. Each Service relies on both the Veterans Administration (VA) and the National Disaster Medical System (NDMS). Each knows that in those systems there is a large, indefinite number of beds, and each Service depends on the regulating function for access to these external beds. The Task Force sought a means to link the military resources remaining in the CONUS, to organize and use them to support all Services' missions, and to identify and incorporate the capabilities of the VA and NDMS. The Task Force designed an organizational structure for the CONUS which will accomplish these functions. In peacetime it will provide for coordination with all health care systems and support activities, and development of plans to accomplish the many health care missions during mobilization. Upon mobilization, the new organizational structure will exercise tasking authority over all residual military health care resources.

2. For the mobilization perspective, the Task Force recognized that the military departments, agencies and

activities have prepared their own mobilization plans, detailing policies and procedures applicable to their members. In many instances these policies and procedures will continue in conjunction with those identified in this integrated plan. For this reason, a precis has been compiled of the mobilization plans of each Service and the many activities and programs. The compilation will serve as a reference for medical mobilization planners and provide them with a broad perspective on military medical mobilization activities.

D. PLAN SUMMARY

1. The primary goal of the Integrated CONUS Medical Mobilization Plan was to integrate the planning process for the best utilization of health care resources in the United States in the event of full mobilization.

2. Analysis of the CONUS base during mobilization included examination of organizational structure, mission requirements, projected residual capabilities, and geographic dispersion of facilities. Three organizational structures exist for military health care delivery: Army, Navy, and Air Force. All three structures or systems have similar missions, and none alone has the resources to accomplish its CONUS mission. There is little evidence of inter-service planning or assistance. Yet, each plans to use the resources of the Veterans Administration and the National Disaster Medical System. Three systems operating independently with similar missions places one in competition with the others for essential and often scarce resources. The Task Force pursued a means to assimilate CONUS residual resources and alleviate competition, to maintain flexibility to meet Service theater and theater support requirements, to sustain the CONUS base, and to accomplish the military health care missions for CONUS. The means selected would have to offer recognized authority, be able to limit the span of control, encompass all the military medical treatment facilities and establish networks for coordinating with both VA and NDMS.

3. The Task Force designed an organizational structure for military health care in CONUS as the means to accomplish these goals. This structure would be capable of system-wide management and review and would have the ability and authority to make considered decisions regarding allocation of resources to ensure comprehensive quality health care in CONUS. The organization is joint service, which preserves service identities of those assigned and it is operational in both peace and war. The structure is based upon geographic areas of responsibility, using the regional boundaries established by the Federal Emergency Management Agency (FEMA). Services command authorities remain in place. However, imposed on each Service structure is a peacetime joint planning activity at both departmental and regional levels. Upon mobilization, the joint planning activities exercise tasking authority over all military health care resources in CONUS, by region. Not included are those Service units which are preparing to deploy to the theater of operations.

4. The joint planning activity or Joint Health Service Planning Agency (JHSPA), has the mission to develop mobilization plans for CONUS using the residual resources of all Services. JHSPA will coordinate with the Veterans Administration and disseminate guidance to the JHSPA regions pertaining to the broad capabilities of the VA and the type of resources support each region can pursue with VA hospitals within its region. Similar coordination will be accomplished with the Department of

Health and Human Services (DHHS), FEMA, VA, and ASD(HA) for military participation in NDMS.

5. Assigned to the JHSPA are ten regional offices, one for each region. These small units are jointly staffed and have planning responsibilities and coordination authority to develop, maintain and exercise regional mobilization plans. The Regional Coordinator, designated in peacetime from within the region, has the responsibility to know the region--its missions, its capabilities, its losses upon mobilization, its VA support and its NDMS capabilities. Upon mobilization the Coordinator will have tasking authority over all residual military health care resources within the region. The regions' higher headquarters is the JHSPA.

6. Within each region, the Coordinator has functional activities and staff support in addition to the joint regional staff.

a. A coordinating committee, comprised of all military regional hospital commanders who advise the Coordinator on the mission responsibilities and resource capabilities of their facilities. The committee may include VA and NDMS members, and is active in peacetime as well as in wartime.

b. Senior advisors, comprised of one from each Service not represented by the Regional Coordinator to

assist in the management of the region upon mobilization. The advisors should be recalled retirees.

c. Joint Patient Administration Teams (JPATs) which are Reserve Component personnel activated upon mobilization to provide regional administrative control and assistance for patients hospitalized in either VA or NDMS hospitals.

d. Regional ASMRO and Regional Blood Program Offices are both activated upon mobilization and designed to ensure the region has regulating ability and blood products support.

7. In addition to the framework for the CONUS organizational structure, statements of responsibility and broad policy guidance have been included in the CONUS plan. Responsibilities have been enumerated for establishment of the joint organizational structure for implementation of the expanded responsibilities upon mobilization. The guidance provided in the plan addresses the use of resources: manpower, logistics and facilities; the operation of health care support programs and services during mobilization: training, regulating, blood program; and finally, coordination with non-DoD systems for support: VA, FEMA, NDMS.

8. During the analyses of planning for mobilization, the Task Force found many issues requiring action. These issues have been developed as findings and are included in the plan as Chapter II. Each finding is accompanied by the Task Force's

recommendations for actions to be taken to overcome or resolve the issue.

9. Finally, Chapter II, Annex B contains a reference for medical mobilization planners. This Annex summarizes each Service's medical mobilization plan and provides details concerning medical support programs during mobilization.

E. MAJOR FINDINGS AND RECOMMENDATIONS

1. The major finding of the Task Force was that within one organization, DoD, there are three health care systems having similar missions and competing with one another for resources. There is no focal point for systems integration or management. Each operates independently without regard to the others. Health care resources, in time of war, will be in great demand by the military services. Priority for their use will be to support the theater of operations. This priority does not diminish the essential and demanding health care missions in CONUS. Each of the Services develops plans to accomplish their assigned mission. Each depends heavily on resources outside DoD. There has been no attempt among the Services to share mission responsibilities. There is no incentive to jointly plan, to jointly staff, to consolidate missions or to share health care responsibilities. Each military health service system considers only the support of its own service. One system is unaware of the other systems in any given geographic area, and across the United States. Operating three independent systems to do the same functions is not the best method for optimizing use of high demand resources. An integrated effort would result in better utilization. The Task Force recommended a joint organizational structure for military health care in CONUS. The structure would function within the joint arena of the Organization of the Joint Chiefs of Staff, would have planning responsibilities and coordination authority in peacetime, and would have tasking authority over residual CONUS resources

in wartime. Chapter I, the Integrated CONUS Medical Mobilization Plan, describes this recommendation in detail.

2. The other findings of the task Force were resource oriented and contributed to the determination of the military health service system capability within the United States. The primary measure of capability is the number of beds a system can produce to care for the estimated number of patients. The sophistication of methods for determining requirements continues to improve; but today, the model does not exist which can describe the specific diagnostic categories for returning casualties and the specific capabilities required. Because it does not exist, DoD has not determined to what point the CONUS health service system can be depleted of its personnel and supplies, and still accomplish its mission. Without this model, facility construction and renovation are based solely on peacetime workload factors, thus falling short of aggregate wartime requirements. There is not sufficient bed capacity in military hospitals in the United States for wartime casualties. It is also questionable whether or not the DoD health service system can meet its requirement to care for casualties who can be returned to duty within sixty (60) days or for casualties who require specialized care not available from other sources. The Task Force recommended that a patient generation model be completed as soon as possible and that the Services use it to determine their definitive requirements.

3. For many years the Services have made up the difference in aggregate numbers of beds available and those required by planning to use Non-Industrial Facilities (NIFs): troop barracks, schools, and morale/welfare/recreation buildings. Yet no standard guidance and/or criteria for such use have been developed. Originally planned for minimal or convalescent care patients, little renovation and upgrade of those facilities was anticipated. The Army now plans to use these facilities for intermediate care patients. More than two-thirds of Army's bed capacity is in these facilities. Criteria for use are essential. Additionally, the time, labor and expense of conversion to patient use must be analyzed in comparison to constructing patient care facilities to meet military mobilization requirements. The Task Force recommended that criteria for use of NIFs as patient treatment facilities be developed. Secondly, the Task Force recommended comparative analyses be made of NIF conversion versus hospital construction.

4. Part of the bed shortfall estimated by the military will be accommodated by the Veterans administration, as described in the VA/DoD Contingency Plan. In fact, DoD uses the VA resources in their planning. VA, however, has been cited by the GAO for having too many operating rooms to support current workloads. The VA backup support for DoD during contingencies has not been considered. The Task Force has recommended that DoD provide the VA with specific DoD requirements in the event the VA/DoD Contingency Plan is implemented. In this way, the VA

can defend its maintenance of acute care capability for support of DoD.

5. The panacea for DoD's shortfall of hospital beds is the NDMS. There is a large commitment of beds by civil sector hospitals and the number continues to grow. It is a voluntary commitment, however, and access to these beds is dependent upon a highly organized, well-trained and equipped group of volunteers in over 70 metropolitan areas within the United States. Responsibility for organizing, training and equipping these volunteers rests with the Federal Coordinator--one per area--who has the assignment as an additional duty. DoD depends on the NDMS for more than half its expected bed requirements. The Task Force has recommended greater emphasis and resourcing be directed toward making the NDMS a viable system.

6. A bed represents only capacity unless proper staffing and equipment are present to provide care and treatment of patients. Then, it represents a capability. As mentioned above, the Task Force recommended a patient generation model be developed to determine requirements. Output from this model should include numbers and types of health care personnel needed to support the CONUS medical missions.

7. The Task Force recommended development of recall systems for military health care retirees. They then may be used to meet specific CONUS requirements rather than as a pool

of talent whose assignment is determined when the time arrives. Second, the Task Force recommended greater, more flexible use of Individual Mobilization Augmentees (IMAs) in identified, critical CONUS positions. Finally, the recommendation was offered to organize Reserve Component (RC) units to backfill CONUS military treatment facilities, as the Army currently does. Each of these recommendations assists in generating the manpower resource for the CONUS health services system.

8. The competition for supplies and equipment during wartime will be fierce, coming from every claimant. The dependence upon foreign sources for raw materials as well as finished products is cause for concern among all DoD logisticians. Stockpiles of supplies for CONUS are not sufficient and continue to receive low priority for funding. The Task Force has recommended that the health care material needs of DoD in CONUS be identified; and, with that information, seek alternative procurement sources, develop wartime CONUS stockpiles, and pursue development of US contingency production capabilities and methods.

- * Specialty mix and numbers of beds
- * Specialty mix and numbers of personnel
- * Supplies and Equipment
- * Space and facilities
- * Graduate Medical Education (GME)

ISSUE: There are insufficient military hospital beds in CONUS to Care for those Patients Generated as a Result of Full Mobilization.

In the late 1970's OASD Health Affairs and the Services discussed development of a patient flow model that could identify, by diagnosis and level of care, specific requirements for health care services at all echelons of treatment. The Army desired, and was given, the tasking for development of this model. In turn, the Academy of Health Sciences began researching and developing the model. During the ensuing years the Academy has made great strides toward completion of this very significant program. However, to date, the work has not been completed.

The Task Force needed a measure to determine whether the CONUS base could accomplish its mission. The requirements had to be matched with capabilities. Without an accurate, approved requirements model, the Task Force created its own, fully recognizing the inherent specious logic. Nevertheless, it provided a measure upon which the capabilities could be assessed.

Further, a capability analysis was requested and received from each of the Services, the Veterans Administration, and the Federal Coordinators reporting NDMS capability. The Task Force then utilized the aggregate POM

requirements, as reported by the Services, as input to the model. The information produced was then sorted into ASMRO categories, Average Length of Stay (ALOS), and Levels of Care groupings. This refined information was then compared to reported capabilities.

The analysis of the health care required for returning casualties of a multi-theater armed conflict, demonstrated a significant bed shortfall within the CONUS base. This includes use of VA and NDMS capabilities. More discrete analysis indicated greater requirements in certain specialties than there are beds in the United States, military or civilian. Examples of these specialties are burn care and orthopedics. DoD has a responsibility to care for those casualties when the specialty care they require is not available elsewhere (ASD, Manpower, Reserve Affairs & Logistics Memo, 1979). Consequently, DoD may need additional specialized hospital beds. However, this possibility must accurately be determined and more precisely defined. The process of casualties returning to CONUS for care relies on patient regulating procedures. During war, regulating of patients is streamlined to handle large numbers quickly. This may result in patients categorized in a subspecialty when they may need less than that type of care; i.e., a categorized burn patient may require only a general surgery bed. Definitive diagnoses must be identified at some point in the evacuation process to ensure

those critical specialty beds are used only for those patients who need them.

FINDINGS:

1. There is an apparent need for additional military hospital beds in CONUS.
2. There is a need for an accurate patient generation model. (See Issue regarding this item, this chapter)
3. There is a need for definitive diagnosis of patients in the evacuation process to ensure regulation to the appropriate type of hospital bed.

RECOMMENDATIONS:

1. OASD(HA) should intensify and increase the NDMS goal of acquiring civil sector hospital beds. Special attention should be paid to identifying civil sector specialty capability in critical shortage areas such as burn care and orthopedics.
2. Projected specialty requirements must be ascertained by using a patient generation model. These requirements must be analyzed by the JHSPA using projected CONUS capability. The number of beds needed in the DoD system must be

projected, acquired, and maintained.

ISSUE: Use of Non-Industrial Facilities (NIFs) in support of the CONUS Medical Mobilization Mission

A review of the Services Medical Mobilization plans reveals that the Army and Air Force are programming personnel, supplies, and equipment for utilization in NIFs in support of their CONUS mobilization bed requirements. This use of NIFs is a critical element of the Army and Air Force efforts to meet wartime casualty care aggregate requirements. The lethality of weapons and the intensity of warfare generate increased requirements for hospital beds. Today DoD cannot build sufficient hospital beds and maintain them in a ready and waiting status. For this reason, buildings other than hospitals are planned for use as patient treatment facilities. In fact, more than half the stated bed capacity of the DoD health service system is in NIFs. On May 19, 1981, the General Accounting Office (GAO) issued a report to Congress that was entitled, DoD Needs Better Assessment of Military Hospitals' Capabilities To Care For Wartime Casualties, HRD-81-56. This report stated that the augmenting of hospital capacity with other facilities needed reassessment. The report revealed that realistic assessments had not been made of construction efforts needed to convert NIFs to medical use. For example, troop barracks currently identified by the Army for potential use as acute care medical facilities hold little promise for immediate conversion to such use in the event of

mobilization for short, intense conflict. Similar problems exist with respect to plans to open inactive hospitals. Such facilities, as well as other buildings, located on military installations could, however, serve as convalescent care facilities.

Medical mobilization planners informed the task force that the Air Force plans to use NIFs to care for minimal care patients, while the Army plans to use them for both intermediate and minimal care patients. There are no standard criteria for use of NIFs. If intermediate level patients are to be cared for in these facilities, criteria must be developed.

The care requirements for intermediate level patients range from constant monitoring to those patients beginning to ambulate and assume some self care. These patients may require monitoring devices, ventilator support, intravenous therapy, frequent suctioning, dressing changes, reinforcement and ambulation. The Army is currently conducting a detailed CONUS Medical Mobilization Assessment (CMMA) and will review all planned use of NIFs.

The Blue Ribbon Panel on Sizing Department of Defense Medical Treatment Facilities (MTFs) concluded that the primary consideration in facility sizing must be to build facilities of sufficient size to accommodate the medical

readiness force. Additionally, the panel recommended that Health Affairs have oversight of all Services' requests for construction, renovation, and upgrade. To accomplish this oversight, ASD(HA) established the Defense Medical Facilities Office.

The Defense Medical Facilities Office has stated that no inpatient medical treatment facility construction projects are being programmed solely to meet mobilization requirements. However, mobilization requirements are to be considered in the general sizing criteria. These criteria, include, at a minimum: readiness, training, beneficiary requirements, recruitment/retention of personnel, resource sharing, remote, underserved site coverage, and political realities. Readiness or mobilization as a criterion has not been defined.

FINDINGS:

1. Mobilization criteria for hospital construction or renovation are not defined, consequently not considered when decisions are made regarding priority and size.
2. Mobilization not being considered in construction or renovation decisions results in hospital bed determinations based upon peacetime workload, which is declining; thus military hospital bed numbers are declining.

3. The Services are planning to use other than hospitals for patients during mobilization since they have no criteria upon which to base mobilization expansion.

4. Planned use of NIFs has been thought out, but not carried out.

RECOMMENDATIONS:

1. That mobilization criteria be utilized in determining both priority and size of construction/renovation projects for military treatment facilities. These criteria should include the following, and be refined by the DMFO in coordination with the JHSPA and OASD(HA) Medical Readiness Division:

- * Regional Office Locations
- * Mobilization Station Locations
- * Establishment/Location of Specialty Centers
- * Casualty Receiving Hospitals

2. That, in coordination with the Services, the Defense Medical Facilities Office publish criteria to be utilized DoD-wide when assessing in-hospital and NIF medical bed expansion capabilities.

3. If the patient generation model identifies a greater requirement for intensive and intermediate beds than exists in the DoD system, careful consideration should be given to changing the guidance that says construction will not be programmed for mobilization. This consideration should include analysis of timing and conversion costs to access NIFs for these patients.

4. If it is determined that the military wartime bed capacity is to be reduced for whatever reason, reduce NIF capacity prior to that of military MTFs.

5. That the services, in conjunction with the JHSPA and Regional Coordinators, conduct individual CONUS medical mobilization assessments on an annual basis.

ISSUE: Criteria for Determining Veterans Administration
Facilities Requirements

On April 29, 1986, the Government Accounting Office issued a report entitled VA Health Care, Too Many Operating Rooms Being Planned, HRD-86-76. This report stated that the VA continues to plan and build too many operating rooms. In discussing the VA construction criteria, and reflecting the GAO model for determining facility requirements, no mention was made of the VA mission to serve as primary back-up to the DoD health care system in the event of war or national emergency. This back-up mission for VA is reflected in Public Law 97-174.

DoD policy prescribes that military patients requiring hospitalization for less than 60 days will be admitted to military Medical Treatment Facilities (MTFs); however, the VA/DoD contingency plan has led to approximately 32,000 VA beds designated for support of the DoD mission. Accordingly, patients requiring less than 60 days hospitalization could be admitted directly to VA facilities when military MTFs are filled. Further, patients expected to return to duty but requiring hospitalization longer than 60 days, as a matter of policy, will be admitted to VA facilities, also. Finally, patients requiring long-term care and not expected to return to duty will be admitted directly to VA facilities, as well. Therefore, if the VA

back-up support mission is not included in the criteria utilized to determine facility requirements, the VA requirements could be understated. This situation is a reflection of DoD's facility planning--the mobilization missions are not incorporated since they have not been defined. The result could be less wartime health care support to DoD.

FINDING: Veterans Administration criteria for determining facilities requirements should include its DoD primary back-up mission.

RECOMMENDATIONS:

1. OASD(HA) should inform VA of specific requirements when the model for patient generation is completed in order to provide the VA with substantive information with which to defend construction of operating rooms and beds.
2. OASD(HA) should formally request that the VA primary health back-up mission for DoD be considered when developing VA facility requirements, and that OASD(HA) be informed when VA facilities earmarked to be primary care centers experience permanent reductions in capability.

ISSUE: DoD must rely on hospital beds provided by NDMS to care for casualties returning from theater(s) of operations.

During mobilization and OCONUS conflict, the mission of the DoD health care system in the United States is twofold:

1) Support the operational forces, and 2) Provide or arrange care for returning casualties:

- * Priority for manpower, money, and materiel goes to deployed forces.
- * Residual CONUS medical manpower is the replacement pool for deployed forces, for the first 60 days of conflict, as a minimum.
- * Appropriate numbers of specialty bed/personnel will not be available within the DoD health care system.

The Veterans Administration, by law, serves as the primary back-up for DoD during mobilization. However, even with the addition of those VA beds, there will not be sufficient beds to care for the projected numbers of casualties.

Within the United States, there are numerous civil sector hospitals. Previously, however, DoD had no way to

access the civil sector during a period of conflict. The National Disaster Medical System (NDMS) was designed to bridge this gap and provide DoD the necessary access. Currently, there are several thousand committed civilian hospital beds to care for military casualties when the numbers or specialty requirements exceed the capability of DoD and VA hospitals.

It was intended that the NDMS support either a civil disaster or a military conflict. To do either, the system was designed to include extensive marshalling of emergency and medical assets within each NDMS metropolitan area. These assets and personnel are to be voluntarily organized. Very few metropolitan areas have organized to date. Only the Federal Coordinator in each area, as an additional duty, has the responsibility to make the NDMS a reality.

The concept of the NDMS is good. For the military to rely on it for returning casualties, DoD needs to commit resources for its own support. DoD needs to make the concept a reality--a system. Questions concerning communications, reporting requirements, triage, patient holding, transportation, accountability, administration, payment, and evaluation need resolution. Each federal coordinating area must ensure the presence of trained personnel in a mobilization scenario.

FINDINGS: There is a commitment of hospital beds within NDMS, but the many other functions to make it a system do not exist today.

RECOMMENDATIONS:

1. OASD(HA) must work with major health care organizations and other Federal agencies to address issues transcending the whole system, to include reimbursement, liability, and training to ensure system development.
2. The Defense Medical Service Support Center (DMSSC), in coordination with the Department of Health and Human Services, should develop, program, and implement both a total data/voice communications system and an information management system for the NDMS in the event of mobilization.
3. The JHSPA should provide guidance and policy implementing direction to Regional Coordinators for their role in establishing NDMS as a system.
4. Military Departments should provide the commitment of resources through the Planning, Programming, Budgeting System (PPBS) to ensure a viable system of support in the event of war to include:

- Manpower to create Reserve Coordinating Teams

in each Federal Coordinating Area

- Materiel to ensure availability of patient holding, communications, transportation
- Money to afford the commitment of manpower and materiel

5. Regional Coordinators, in annual NDMS exercises, should test the ability to communicate between facilities, transportation linkages, provisions for patient reception, accountability and administration, and interface with local airports.

ISSUE: Critical Personnel Shortages in CONUS Medical Treatment Facilities (MTFs) Upon Mobilization

The numbers of mobilizing reservists from M-Day through D+90 will generate a major workload for the CONUS medical base. Mobilizing reservists for the four services combined will reach the 1 million range at M-Day. At D+60, the aggregate will be more than 1.7 million. Accordingly, staffing in CONUS MTFs is a critical issue. Active Component personnel will be processing for deployment as will the mobilizing Selected Reserve (SELRES). Individual Ready Reserves (IRRs), Standby Reserves (SBRs), Individual Mobilization Augmentees (IMAs), Retired Regular and Reserve personnel will require initial in-processing at the same time. Of course, mobilizing medical reservists will themselves require processing before they can replace their Active Component counterparts and begin to support the expanded medical mission.

Officer and enlisted IRR/SBR medical personnel reporting to mobilization stations/installations represent only a tenuous manpower pool which may be decremented by assignments to deploying Active Component units, as well as by intra-command or regional transfers resulting from mobilization cross-leveling or cross-Service assignment.

Health service needs are heavily dependent upon the Reserve

Component. For example, more than 80% of the medical assets of the Army are in the Reserve. Yet, Reserve manpower contains the inherent limitations of efficacy of previous skill qualification, skill decay, and skill shortages. Some of these problems are exacerbated by the resistance of prior service personnel to affiliate with the Reserve Component because of a dislike of drill requirements in the SELRES, and the prospect of deployment. IMA personnel must report within the first 30 days of conflict, normally earlier than the IRR. The expanded utilization of IMA billets would obviate many of the problems of manpower planning for the Services, as well as objections to affiliation with the Reserve Component among personnel.

FINDING: IMAs should be programmed to ensure early assignment in critical specialties in CONUS MTFs.

RECOMMENDATIONS:

1. Each CONUS MTF should review critical skills and/or shortfalls and program for IMAs on mobilization manning documents so as to effect some degree of control over critical personnel fills in CONUS at peak periods. Review should be based on mobilization mission requirements. Each MTF review should be analyzed at regional level to ensure regional requirements for health services are being addressed in the most effective manner. Regional analyses

will consider potential capabilities of both VA and NDMS to support military MTFs.

2. Regions should report their recommended staffing requirements by time frame to the JHSPA. The JHSPA will work with the Services to determine the minimal essential staffing for the CONUS.

ISSUE: Medical Processing of Mobilizing Reservists

Upon mobilization the sheer numbers of mobilizing reservists will create major processing requirements for the CONUS medical base. At the same time, Active Component medical personnel will be outprocessing for deployment, thereby diminishing the capability to handle an increased workload. Individual Ready Reserves, Standby Reserves and Individual Mobilization Augmentees mobilizing to replace Active Component personnel will themselves require medical processing prior to supporting this mission. Second, both the deployment processing and the initial in-processing will create requirements for large quantities of serums and vaccines as well as protective mask optical inserts, spectacles, and hearing aids. These requirements could outstrip industry's capability to provide in a timely manner.

FINDING: Medical processing upon mobilization needs to be minimized.

RECOMMENDATIONS:

1. The Services should define requirements for all items of supply required by activating Reserve Component personnel and for vaccines and serums required by both the activating forces and the deploying forces.

2. Services should develop systems to ensure that their Selected Reserves remain current in immunization requirements and are provided spectacles, protective mask optical inserts and hearing aids during peacetime.

3. The Defense Personnel Support Center should ascertain industry's capability to surge vaccine and serum production necessary to meet mobilization requirements. Should the capability not be sufficient, DPSC should initiate appropriate industrial preparedness measures to obtain the capability.

ISSUE: Retiree Recall Programs

A review of personnel procedures among the Services revealed that the U.S. Army has the only retiree recall system that is developed to a degree where retirees are issued hip pocket orders that direct them to report to specific installations when called.

The legislative basis for the Army Retiree Recall Program is vested in Title 10, U.S.C., Section 688. Provisions of the law apply:

- * Section 688 addresses Regular and Reserve Retirees who have completed 20 years of active service. It authorizes the Service Secretaries to recall these retirees at any time in the interest of national defense.

The legislative authority for the call up/mobilization of Reserve Retirees is Title 10, U.S.C., Section 672. Provisions of the law apply:

- * Section 672 provides authority to recall the remaining Reserve retirees contingent upon the following: A Congressional declaration of war/national emergency, and the Secretary of Defense's concurrence in

a Service Secretary's determination that there are no other reserves available in the required category.

The program provides for recall during mobilization, national emergency, or war. As such, retirees may be recalled at partial, full, or total mobilization. However, Army regulation 601-10 does not provide authority to recall retirees in support of a 200,000 pre-mobilization call-up. Retirees are subject to involuntary pre-assignment orders until they reach the age of 60.

Army retirees are pre-assigned to Active Component non-deploying CONUS Table of Distribution and Allowances (TDA) and Mobilization TDA units. Pre-assigned twenty-year Active Duty retirees will be needed to assist in the receiving and processing of soldiers ordered to Active Duty in the early stages of mobilization, and will permit reassignment of Active Duty Army personnel for deployment. With more than 1 million Army reservists mobilizing within the D+60 time frame, and more than 1.7 million mobilizing for the four services, combined, for that period, the need for retiree augmentation is well demonstrated, particularly at designated mobilization and training stations.

As a relatively new personnel program, the Army Retiree Recall Program potentially could be enhanced through regular

exercising, resulting in improved planning.

The Services' medical mobilization plans reflect that retirees will be significantly utilized. To effectively use this personnel resource during mobilization, planning is needed today. Systems must be developed and tested, procedural problems resolved, and the systems continually improved to ensure that retirees can be activated and assigned to units in a timely manner.

FINDING: Recall systems for Medical Department retirees are required for all Services.

RECOMMENDATIONS:

1. The Services' mobilization personnel authorization documents should identify positions suitable for fill by retirees during mobilization.
2. Each of the Services should comply with the Defense Guidance to develop and maintain a recall system that will facilitate the activation and assignment of medical department retirees during mobilization.
3. Each Service should coordinate with the JHSPA concerning billets identified for retiree fill, to contribute to development of regional plans and cross-Service sharing.

ISSUE: Industrial Capability for Production of Medical
Materiel Items

Perhaps the test statement of defense industrial base issues today is contained in the December 31, 1980 report of the Defense Industrial Base Panel of the House Armed Services Committee:

- The defense industrial base is unbalanced; excess production capacity at the prime contractor level is not matched by capacity at sub-contractor levels.
- The industrial base is not capable of surging production in time to meet a national emergency.
- Skilled manpower shortages exist now and are projected to continue.
- The United States is becoming increasingly dependent on foreign sources for critical raw materials and for some specialized components for military equipment.
- Capital investment in new technology, facilities, and machinery has been constrained by inflation, unfavorable tax policies and management priorities.

Discussions with the Medical Industrial Preparedness

Planning Section at the Defense Personnel Support Center (DPSC) confirm that the problems identified above for the entire defense industrial base also exist for medical supplies and equipment, and that there has been little improvement since 1980.

Dependence on foreign sources has evolved because those sources are able to produce and sell items such as surgical instruments at lower prices than domestic manufacturers. Consequently, the competition has reduced U.S. capability to produce those items. Furthermore, costly litigation and a lack of demand for items such as vaccines has resulted in a diminished capacity for surge production within the United States.

Dependence on foreign sources could be offset by increased stockpiling, but shelf life considerations and the lack of a well defined wartime requirement have compounded the difficulties associated with such stockpiling. Consequently, it is difficult to assess the full magnitude of the problem.

FINDINGS:

1. Foreign competition has eroded the U.S. industrial capability for production of many medical materiel items.

2. There is a diminished surge production capacity in the U.S. for many medical items including morphine sulfate, broad spectrum antibiotics, intravenous solutions, atropine, pralidoxime injectable, smallpox vaccine, surgical instruments, and camouflage bandages and first aid dressings.

3. DoD urgently needs a wartime medical materiel requirements generation model.

RECOMMENDATIONS:

1. OASD(HA) Medical Readiness Division should pursue the development of a computer model to determine the medical materiel requirements for each wartime operational scenario.

2. The Medical Industrial Preparedness Section of DPSC should examine the domestic capability for production of key medical items and, in conjunction with the Defense Medical Standardization Board, determine a stockpile procurement priority for each. Prioritization should be based on that which would be the most essential and the most difficult to obtain.

3. The Medical Industrial Preparedness Section at DPSC should assess domestic industrial capability to provide for production of critical items through all stages of the

production process, including dependence upon foreign subcontractors and foreign sources of raw materials.

4. The Medical Industrial Preparedness Section at DPSC should accelerate implementation of industrial preparedness measures to ensure domestic sources of supply. The following listing provides examples of measures that have already been attempted and/or implemented. Such measures are applicable to other items of critical medical resources.

a. Encourage domestic industry through other Government programs.

Example: The use of surplus Government machinery and equipment to foster minority enterprise for production of medicine chests.

b. Prestock components.

Example: Prestocking of critical items such as nerve agent antidotes (atropine, injector components) would reduce production lead time during mobilization.

c. Develop alternative sources and foster competition.

Example: Alternative sources have been established for burn cream and atropine.

d. Encourage industry storage and industry stock rotation of dated and deteriorative items.

Example: Contracts have already been signed for industry stock rotation of burn cream and for other dated and deteriorative items.

e. Examine feasibility of extending shelf lives of war readiness stocks already on hand with the Food and Drug Administration and the pharmaceutical manufacturers.

Example: This program has already met with some degree of success.

f. Ensure facility modernization through use of multi-year contracts.

Example: Use of multi-year contracts has enabled industry to improve its production capability and ensured a source for smallpox vaccine.

g. Restrict procurement to domestic sources.

Example: Active restricted contracts exist for procurement of tetracycline capsules.

h. Restrict procurement to planned producers.

Example: Letters of agreement exist for procurement of 146 of the surgical instruments in greatest demand for mobilization requirements. Procurement is strictly limited to U.S. and Canadian producers who must use domestic steel and forgings in production of these instruments.

i. Ensure availability of critical items by increasing war reserve protectable stocks.

Example: DPSC has recommended increased stockage of camouflage bandages to DLA.

5. The Medical Industrial Preparedness Section at DPSC should examine other potential alternative solutions, to include military research and development efforts.

ISSUE: Identification of CONUS War Reserve Materiel (WRM)
Requirements

The Defense Guidance and DoD Directives 3005.5 and 4140.2 define criteria and policy for establishment and management of war reserve materiel stocks. They establish responsibility and authority with DoD components to select items for war reserves which are necessary to support their war, contingency, and or mobilization plans. DODD 3005.5 also establishes criteria that would preclude items from being selected for war reserves. Two of these criteria are: Items normally available from commercial sources in sufficient quantities and in the time required to meet wartime military demands; and items possessing deteriorative or unstable characteristics to the degree that the storage time period is limited unless they can be effectively rotated through normal issue or considerations of overriding military effectiveness prevail.

DODD 3005.5 also recognizes that not all required quantities of selected items may be acquired or stocked due to economic constraints beyond the control of the individual DoD component. Awareness of the funding situation should not, however, inhibit the planning, identification, and selection of items vital to the approved wartime mission.

The components have identified theater WRM requirements and

programmed sufficient funds to satisfy the prepositioned war reserve materiel requirements by FY 1992. They have also taken measures to extend the shelf lives of dated and deteriorative items and have developed innovative techniques to defer DoD financial risk for those items, such as contracting with vendors to store materiel items within contractor-owned facilities, arranging for those items to be rotated by the contractor through the contractor's normal inventory. This procedure ensures that DoD stocks do not become outdated and defers a large portion of the financial loss associated with outdated materiel stocks to the vendor.

The components have not fully identified CONUS WRM requirements, however. This is partially the result of their concentration on the operational theater and partially resulting from undefined CONUS patient workload requirements.

FINDING: CONUS requirements for War Reserve Materiel have not been identified.

RECOMMENDATIONS:

1. OASD(HA) should pursue development of a computer model for defining the anticipated CONUS patient workload. The model should then be used by the Service components to identify their CONUS WRM requirements.

ISSUE: Repair, Refurbishment, and Redistribution of
Aeromedical Evacuation Materiel Items

During the Vietnam conflict numerous litters and equipment items were returned with patients to CONUS. No method existed to repair, refurbish, or redistribute these items to the originating facility or to the supply system. Such a method still does not exist today. Consequently, as another conflict would result in numerous litters, blankets, and equipment items being returned to CONUS with patients, depleting stocks within the theater(s) of operation and resulting in an accumulation in the United States. The loss of equipment and litters is expected to be exacerbated with the use of Veterans Administration and civilian hospitals for military casualties. Within the JHSPA Regional System, Regional Coordinators will establish a consolidation point for litters and equipment items removed from aeromedical evacuation aircraft. Each incoming aircraft will be met by a medical logistics officer who will identify and list all materiel items accompanying patients. The list will include the patients' destination hospitals.

Receiving hospitals will be requested to take reusable items to a consolidation point within the region and Regional Coordinators will make the final determinations as to the condition of these items and whether or not they can be economically repaired/refurbished. Litters, litter pads,

litter straps, and litter patient restraint sets will be reported to the designated DLA depot for disposition instructions. For those items that the DLA item manager directs to be returned, the DLA will ensure these items are refurbished/cleaned and redistributed to theater facilities through normal MILSTRIP supply channels at a reduced price. Technical medical equipment items such as defibrillators, patient monitoring systems, ventilators, etc. will be processed in accordance with the Aeromedical Evacuation Equipment Supply Return Program procedures to be developed by the Defense Medical Standardization Board.

FINDING: An integrated system does not exist to retrieve, repair, refurbish, and redistribute materiel items returned on aeromedical evacuation aircraft.

RECOMMENDATIONS:

1. The Defense Logistics Agency should:

a. Identify depot locations to receive reports of excess litters, litter pads, litter straps, and litter patient restraint sets determined by the Regional Coordinator to be eligible for refurbishment and/or cleaning and return to DoD supply system inventories.

b. Develop, in conjunction with the Joint Health

Service Planning Agency and the Regional Coordinators a formalized concept for the reporting, shipment, and contract refurbishing/cleaning of excess litters, litter pads, litter straps, and litter patient restraint sets.

2. The Defense Medical Standardization Board should develop a formalized concept for the reporting, shipment, and contract refurbishing of technical medical equipment items such as defibrillators, patient monitoring systems, ventilators, etc. that accompany patients processed through the aeromedical evacuation system.

CHAPTER III

SECTION A TO CHAPTER III, ICMMP

LEVELS OF MOBILIZATION

1. Levels of Mobilization

a. Mobilization. The process of preparing for war or other emergencies by assembling and organizing personnel and material for active military forces, activating/federalizing the Reserve Component (RC), extending terms of service, surging/expanding the industrial base and bringing the US Armed Forces to a state of readiness for war or other national emergency. Involuntary activation of the RC includes the following categories of force activation:

(1) Selective Mobilization. Mobilization by the Congress and/or the President of RC units, Individual Ready Reservists, and the resources needed for their support to meet the requirements of a domestic emergency (e.g., postal strike, flood, earthquake, etc.) that does not involve a threat to the national security.

(2) Partial Mobilization. Mobilization by the President of not more than 1,000,000 Ready Reservists (units and individual reservists) for not longer than 24 months, and the resource needed for their support to meet the requirements of

war or other national emergency involving an external threat to the national security (10 USC 673).

(3) Full Mobilization. Mobilization by the Congress of all RC units in the existing force structure; all individual, standby, and retired reservists; retired military personnel; and the resources needed for their support for the duration of the emergency plus six months to meet the requirements of a war or other national emergency involving an external threat to the national security (10 USC 672).

(4) Total Mobilization. An unspecified expansion of the Armed Forces by the Congress to organize and generate additional units or personnel beyond the existing force structure, and the resources needed for their support, to meet the total requirements of a war or other national emergency involving an external threat to the national security.

(5) Presidential 200,000 Selected Reserve Call-up Authority. Activation of not more than 200,000 Selected Reservists by the President, and the resources needed for their support, for no longer than 90 days (plus 90 days if warranted) for any operational mission without a declaration of national emergency (10 USC 673b).

(a) The 200,00 figure represents the total Selected Reserve members called to active duty during this time frame. If some reservists are released from active duty early,

others may be activated as long as the total remains within the 200,000 ceiling and the original 90-day duration is not exceeded. No limit exists for reservists who volunteer for active duty and are called to active duty under some authority other than Title 10 USC 673b. The President may utilize the authority when he determines it necessary to augment the active forces for any operational mission. This authority is not meant to circumvent existing controls on active duty end strengths through successive call-ups of Reservists. The 90-day duration for activation is sufficient to clarify the operational situation and ascertain whether some degree of national mobilization is required or that no further need for augmentation of active forces exists.

b. Impact on CONUS Medical Base. With a 200,000 Selected Reserve Call-up, requirements for medical processing in the CONUS medical base would be manageable in that these reservists theoretically would be medically qualified. Beginning with a partial mobilization (1 million), the impact of any increased levels of mobilization would strain the CONUS medical base, although the curtailment or limiting of dependent and retiree care in military Medical Treatment Facilities (MTFs) would provide additional capacity. Full or total mobilization, expanding to the existing approved force structure and beyond it, respectively, would begin to peak at D-Day simultaneous with the deployment of Active Component (AC) personnel from CONUS MTFs, arrivals of activated Reserve Component/National Guard (RC/NG)

units, and the expansion of the CONUS training base. These levels of mobilization would severely strain the CONUS medical system. With casualties beginning to return from the Theater of Operations (TO) subsequent to deployment, the situation will be further exacerbated. RC medical units designated as augmentation to CONUS MTFs and/or late deploying RC units could assist in meeting processing demands in CONUS. Data in Table III-A-1 demonstrate that the effect at full mobilization of mobilizing reservists on the CONUS medical base will be dramatic.

(1) In the case of Air Force, approximately 64% of the mobilized reserves, through all time periods, are in the Selected Reserve (SELRES) category which will require, therefore, only minimal medical processing associated with mobilization. For Navy, SELRES comprises 100% of mobilizing reservists from M-Day until approximately D-Day, but averages only 55% through D+90. SELRES comprises 58% of mobilizing reservists in the Marine Corps at M-Day, 44% at approximately D-Day, but then decreases to approximately one-quarter of the total through the remaining periods. The percentages for Army are similar to Air Force, yet it is recognized that the actual numbers of personnel are much greater. At M-Day, SELRES comprises 100% of mobilizing Army reservists and 99% at approximately D-Day. Through remaining time periods, the percentage averages 66%.

(2) It must be emphasized that planned deployment of Active Component Army, Navy, and Air Force medical personnel to the overseas theater will significantly deplete CONUS MTFs, particularly in the case of Navy and Air Force which will virtually leave a shell for their CONUS medical base. Thus, the impact of reserve/guard personnel being brought on duty who will require care and/or medical processing is magnified.

TABLE III-A-1
AVERAGE MOBILIZING RESERVE/GUARD PERSONNEL*
BY TIME PERIOD
(Cumulative and In 000's)

PERIOD	M-Day	D-Day	D+30	D+60	D+90
<u>AGGREGATE</u>					
ARMY	705.3	735.0	1037.8	1061.4	1085.6
NAVY**	179.5	207.9	332.5	349.1	357.8
AIR FORCE	<u>187.8</u>	<u>187.8</u>	<u>287.6</u>	<u>295.1</u>	<u>296.6</u>
TOTAL	1072.6	1130.7	1657.9	1705.6	1740.0

*Includes Retired Reserve and Regular

**Includes Marine Corps

NOTE: M-Day includes portion activated during 200K Call-Up.

SOURCE: POM 88-92 Wartime Manpower Planning System

III - A - 6

SECTION B TO CHAPTER III, ICCMP

CURRENT MOBILIZATION PRACTICES

1. Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)).

a. Purpose. To describe how OASD(HA) participates in mobilization activities.

b. Discussion.

(1) Concept. Upon activation of the Office of the Secretary of Defense (OSD) Crisis Management System (CMS), OASD Health Affairs (HA) implements crisis policies, guidance and procedures. OASD(HA) components of the CMS are:

(a) Representatives to the Crisis Coordination Group, the OSD operations center, which functions 24 hours a day, seven days a week, throughout the Crisis.

(b) The Medical Readiness Policy Advisory Committee (MRPAC) which meets at the call of the Chairman to address and resolve military health care issues resulting from the crisis situation.

(c) The Defense Health Council (DHC) which meets at the call of the Chairman to resolve issues referred by the MRPAC, issues raised by a Council member, or issues presented by other federal or civilian organizations; and, to provide and exchange information rapidly concerning the crisis.

(d) The Assistant Secretary of Defense for Health Affairs (ASD(HA)) participation on the Secretary of Defense (SECDEF) Crisis Management Council.

Most peacetime activities of OASD(HA) continue to be accomplished during crisis and mobilization. Specific mobilization and wartime functions of OASD(HA) are summarized in the following paragraphs.

(2) Manpower.

(a) Direct cross-military service utilization of health care personnel.

(b) Direct intensified recruiting efforts, to include gaining assistance from national professional organizations and associations.

(c) Direct incorporation of the commissioned officer corps of the U.S. Public Health Service into the military services.

(d) Submit legislation to conscript health care professionals. Anticipate first yield in about 65 days, and in 90 days about 20,000 personnel.

(3) Training. Direct military services to regulate training programs to gain the maximum output. This includes inter-service sharing of training resources and use of civilian medical education resources.

(4) Logistics.

(a) Through the Defense Medical Standardization Board (DMSB), ensure allocation and substitution of critical medical supplies.

(b) Monitor Defense Logistic Agency/Defense Personnel Support Center (DLA/DPSC) acquisition of medical materiel.

(5) Facilities.

(a) Activate the Veterans Administration-Department of Defense (VA/DoD) Contingency Plan and the National Disaster Medical System.

(b) Manage military medical facility construction resources.

(c) Determine which, if any, medical military construction projects to cancel for diversion of resources to the mobilization effort.

(d) Assist the Armed Services Medical Regulating Office (ASMRO) when available CONUS beds in specific specialties are filled.

(e) Ensure operation and full integration of wartime information systems, to include Defense Eligibility and Enrollment System (DEERS), Defense Medical Regulating Information System (DMRIS), NDMS/VA/DoD communication links, Reportable Disease Data Base, and logistics.

2. Defense Logistics Agency (DLA) Defense Personnel Support Center.

a. Purpose. To delineate the mobilization planning responsibilities of the Defense Logistics Agency (DLA) and its component, the Defense Personnel Support Center (DPSC), as the integrated materiel manager for centrally managed medical materiel. DLA is established as a separate agency of the Department of Defense under the direction, authority, and control of the Assistant Secretary of Defense Production and Logistics) (ASD(P&L)). It shall consist of a Director and such subordinate organizational elements as are established by the

Director within resources authorized by the Secretary of Defense. The DPSC and DLA:

- (1) Maintain liaison with civilian industry.
- (2) Procure, store, distribute, and manage medical materiel.
- (3) Coordinate industrial preparedness planning.
- (4) Provide support of time-phased requirements for DLA-managed items, contracting administration and property disposal.

b. Discussion. The Defense Logistics Agency:

(1) Provides demand data information to the military services for the calculation of their total (OCONUS and CONUS) medical and dental War Reserve Materiel (WRM) requirements. These requirements consist of all medical materiel in the quantities necessary to establish, maintain, sustain, and expand medical facilities on a worldwide basis.

(2) In liaison with the military departmental agencies and the Federal Emergency Management Agency, evaluates suitability and negotiates use of non-industrial facilities not

under the Department of Defense control needed to support regional medical requirements for mobilization.

(3) Upon authorization of the Office of the Assistant Secretary of Defense (Health Affairs) and when requested by the Armed Services Blood Program Office, activates the standby contracts for procurement of blood products from civilian sources.

(4) Procures and stockpiles plasma expanders, both natural and synthetic, and other blood products in accordance with guidance provided by the Armed Services Blood Program Office and the Defense Medical Standardization Board.

(5) Continues contracting and production support for identified medical and dental materiel requirements. Within the contracting function, emphasis will be placed on expediting production under existing contracts and accelerating the placement of new contracts.

(6) Assists contractors to produce critical items through the use of pre-M-Day industrial preparedness measures such as multi-year contracting, facility modernization, and underwriting the establishment and maintenance of U.S. production sources for critical defense materiel.

(7) In conjunction with the Defense Medical Standardization Board and the military services determines a priority allocation methodology for allocating critical items of medical materiel and monitors stock positions of those items; provides for increased contract and production surveillance, as appropriate.

(a) Identifies the relative importance of competing resources through the use of priority designators. The priority designator provides a means of assigning relative ranking to competing demands. Requisitions of equal ranking are treated on a "first come, first served" basis.

(8) Provides flexible and responsive support to customers under emergency situations by:

(a) Expanding operations at Emergency Supply Operations Centers to provide focal points within HQ DLA and its components for resolution of supply problems.

(b) Performs contract administration service functions under Federal Acquisition Regulations (FAR) and Defense Logistics Acquisition Regulations (DLAR).

1 Uses exceptions to policies and procedures (as provided for by DFARS 6.302.3) to foster domestic industrial capability such as: Contracting without providing

for full and open competition under 10 U.S.C. 2304(c)(3) or 41 U.S.C. 253(c)(3) when necessary, to include maintaining availability of a domestic emergency production source; maintaining an essential engineering, research, or development capability; or providing for an adequate industrial mobilization base.

2 Implements, when required, emergency powers such as authority to deviate from contracting restrictions under Federal Acquisition Regulation (FAR) 1.404.

(9) In conjunction with the Defense Medical Standardization Board and the military services maintains item sustainability listings and provides substitute materials, when required.

(a) In conjunction with the military services, DLA conducts Production Base Analyses (PBAs) and works with industry to ensure total materiel production requirements will be met during surge and mobilization situations.

1 PBA assesses the contractors' capabilities to meet surge and mobilization requirements and their commitments to participate in the Industrial Preparedness Planning Program. The PBA identifies sustainability deficiencies, resource requirements, planning actions, and needed improvement actions.

2 The PBA provides information for planning, programming, and budgeting for industrial preparedness measures and for long-range plans to sustain and improve the defense industrial base. Results of the PBA analysis are briefed to OASD(P&L) and the OJCS for subsequent decision as to inclusion in the planning, programming and budgeting system.

(10) Pursues mobilization initiatives to ensure availability of drug items in sufficient quantity to satisfy mobilization requirements, to include:

(a) Contracting for longer potency dated items.

(b) In conjunction with the Defense Medical Standardization Board and the Food and Drug Administration, extending potency dates after purchase of potency and dated items.

(c) Use of multi-year procurement contracts.

(d) Creating or maintaining required domestic capability for production of critical supplies by limiting competition to items manufactured in the United States and Canada, through use of Federal Acquisition Regulations.

(11) Through use of blanket purchase agreements, ensures adequate commercial maintenance or repair capability

exists to meet readiness requirements for items of materiel not supported by depot maintenance capability.

(12) Coordinates mobilization transportation requirements with common-user transportation resources assigned or available to the Department of Defense for distribution of medical supplies and equipment.

(13) Establishes emergency requisition processing and materiel issue procedures in the event that equipment failure, natural disaster, or enemy attack may render a defense supply center inoperative.

3. Organization of the Joint Chiefs of Staff

a. Purpose. To describe how the Joint Chiefs of Staff (JCS) Support mobilization.

b. Discussion.

(1) The OJCS provides guidance for coordination of Service mobilization to NCA and determines that impact of mobilization capabilities and decisions on the adequacy, sustainability, and feasibility of OPLANs. OJCS also enhances defense industrial preparedness through coordination of Joint Industrial Mobilization Planning Process (JIMPP) with warfighting requirements and plans.

(2) Director for Manpower and Personnel, OJCS (J-1).
In collaboration with the Directors for Operations (J-3),
Logistics (J-4), Plans and Policy (J-5), and JSOA:

(a) Reviews and validates mobilization-related
manpower requirements, identifies options for obtaining
mobilization manpower, and recommends appropriate authorities.

(b) Reviews procedures for allocation /priori-
tization of personnel to Services by the Selected Service
Administration.

(c) Monitors Service call-up of reservists to
ensure authorized ceilings are not exceeded (e.g., 200,000
Selected Reservists or 1 million Ready Reservists involuntarily
on active duty at any one time).

(3) Director for Operations, OJCS (J-3)

(a) In collaboration with the Directors for
Manpower and Personnel (J-1), Logistics (J-4), and Plans and
Policy (J-5), provides recommendations to the Joint Chiefs of
Staff relative to Service allocation of the 200,000, and 1
million reserve personnel.

(b) Maintains JCS Unit Status and Identity

Report to provide readiness data on units in the force structure.

(c) Assesses activation of Naval Control of Shipping Organizations (NCSORG).

(d) Conducts annual review of OPLANs and CONPLANs for conventional operations.

(4) Director for Logistics, OJCS (J-4). Acts as the OJCS point of contact with OSD, Services, unified or specified commands, and agencies for mobilization matters:

(a) Provides mobilization direction and priorities for JOPES. Publishes and maintains mobilization-related doctrine, policies, procedures, and reporting instructions.

(b) In collaboration with the Director for Manpower and Personnel (J-1), provides recommendations to the Joint Chiefs of Staff relative to the manpower mobilization requirements of the Armed Forces and the need for implementing the draft.

(c) Participates in industrial mobilization planning, publishes the CINCs' Essential Sustainability Items

(ESI) List (in JSCP, Annex B) and also publishes the Commanders-in-Chief Critical Items List (CINCIL) which identifies and prioritizes material and weapon systems critical to OPLAN implementation and warfighting that may require industrial base support; reviews requirements for, and requests initiation of, surge production of essential combat equipment and material to OSD.

(d) Collaborates with the JDA, TOAs, OSD, and civil agencies to:

1 Identify transportation requirements that cannot be satisfied by organic DoD transportation assets.

2 Monitor intra-CONUS and inter-theater movements implemented to support theaters of operations.

3 Assess the capability of the national transportation system to meet the simultaneous demands of mobilization and deployment.

4 Identify and obtain the authorities required to acquire transportation assets or services from the civil sector.

5 Request authority for activating the CRAF Stages II/III.

6 Determine requirements and initiate requests for requisition of US-flag and US-owned foreign merchant shipping and to activate the National Defense Reserve Fleet (NDRF) to meet increased sealift shipping requirements.

7 Request allocation of specified CONUS commercial ocean terminal facilities for extended use by DoD.

8 Review the need for OSD to set aside emergency funds or to authorize emergency spending for CONUS transportation assets.

(e) Makes recommendations for coordinating military mobilization with related civil mobilization efforts.

(f) Prepares/consolidates progress reports for the Joint Chiefs of Staff on mobilization activities.

(g) Assesses medical assets identified for mobilization to assure adequate medical resources are available during all stages of war, and monitors the implementation of medical capabilities.

(h) Prepares assessment of the manpower feasibility of recommended OPLANs. Prepares assessment of the feasibility of material objectives and military strategies in

light of industrial and manpower mobilization requirements and capabilities.

(i) Chairs the Steering Group for JIMPP and coordinates industrial preparedness efforts of the OJCS. Thus includes participation in the FEMA resources preparedness system with other executive agencies.

(5) Director for Plans and Policy, OJCS (J-5)

(a) With the Directors for Manpower and Personnel (J-1), Operations (J-3), and Logistics (J-4), develops justification for submitting recommendations to the NCA on the level of mobilization authority required and the need for implementing the Selected Service.

(b) Ensures timely completion of the Joint Strategic Planning system (JSPS) cycle so the the Services can finalize their mobilization plans to support OPLANS calling for mobilization.

(c) Collaborates with J-3 in the review of operations plans for compliance with total force structure guidance issued in the current JSCP.

(6) C3S Directorate. In mobilization matters, acts as the OJCS focal point for C3S technical and operational inter-

operability for joint operations of tactical and strategic command and control systems, including systems being developed and acquired by the Military Services, in coordination with unified or specified commands.

(7) Joint Deployment Agency

(a) The Joint Deployment Agency (JDA) serves as the JCS coordinating authority for deployment planning which is the use of systems and measures for planning, coordinating, and monitoring CONUS movements and deployments of mobilized military forces and material.

(b) The Services mobilize and prepare units for deployment. The JDA coordinates the movement of deploying forces using common user lift from home station and/or mobilization station to port of embarkation and deployment to port of debarkation (POD) and monitors movements that do not involve common-user lift.

4. Army

a. Purpose. To describe how the U.S. Army Medical Department (AMEDD) supports Mobilization.

b. Discussion.

(1) General Concept. Coordinated efforts between the Office of the Surgeon General (OTSG) and Health Services Command (HSC) are directed to ensure that the Army Medical Department (AMEDD) efficiently expands the health care treatment base in CONUS to support the mobilizing and deploying force and returning theater-generated patients. Detailed planning guidance provides for decentralized execution and delivery of all essential health services within the AMEDD's area of responsibility to the expanded Army for selective, partial, or full mobilization. Each Medical Department Activity/Medical Center (MEDDAC/MEDCEN) that will operate as an inpatient facility during mobilization is required to prepare a mobilization expansion plan. Dental services support is reflected in the DENTAC mobilization plans, and are included in the supporting MEDDAC/MEDCEN plans. Hospital bed requirements that are anticipated for full mobilization from M-Day through M+6 months are reflected in the current Program Objective Memorandum (POM). AMEDD mobilization planning centers on the following:

(a) Limitation of inpatient and outpatient services on M-Day for active duty military and civilian employees (occupational health services) only.

(b) Orderly discharge or transfer of all non-military inpatients to civilian or other federal hospitals by M+7 days.

(c) Provision of assistance through CHAMPUS advisory offices to eligible beneficiaries seeking care from civilian health sources.

(d) Expansion in operations of occupational health clinics located on Army Materiel Command (AMC) installations.

(e) Provision of installation medical support to mobilizing and deploying units, to include medical and dental examinations, operation of troop medical clinics, evacuation of patients from training sites and ranges, immunizations, optometry services, medical support to Sea Ports of Embarkation (SPOEs), Aerial Ports of Embarkation (APOEs).

(f) Provision of AMEDD professional officer fillers to deployed and deploying forces.

(g) Augmentation of HSC facilities from Individual Ready Reserves (IRRs), Individual Mobilization Augmentees (IMAs), Retirees, and non-deploying Reserve Component units.

(h) Expansion of the AMEDD training base at the Academy of Health Sciences, (AHS), and selected MEDCENS/MEDDAC/Activities to provide initial AMEDD training to new accessions and retraining of prior service personnel as appropriate.

(i) Responsibility for health care and treatment at Enemy Prisoner of War (EPW) camps if they are established in CONUS.

(j) Military Enlistment Processing Stations (MEPS) will be supported by the MEDCEN/MEDDAC. This support will consist of medical equipment maintenance support and clinical evaluation and/or hospitalization for inductees when required.

(2) Mobilization Programs.

(a) Manpower.

1 The Surgeon General is responsible (for the management of AMEDD officer personnel) to bring overseas deployed units and Active Component Forces Command (FORSCOM) deploying units up to full Table of Organization and Equipment (TOE) AMEDD officer strength. This responsibility is met primarily by the predesignation of officers within USAHSC through the Army Medical Department Professional Officer Filler System (PROFIS).

2 In general, priorities for distribution of AMEDD officer personnel are in accordance with the DA Master Priority List (DAMPL). Broad priorities for planning purposes are as follows:

a Fill of forward based units to Authorized Level of Organization (ALO-2) personnel levels in accordance with OPLAN requirements.

b Fill of deploying units to ALO-2 personnel levels.

c CONUS sustaining base requirements.

3 During mobilization, the installation commander is the authority for cross-leveling of AMEDD personnel assets (within MACOMs), both officer and enlisted. The Director of Health Services (DHS), as the special staff advisor to the installation commander, provides advice/expertise in the accomplishment of the AMEDD cross-leveling task. Cross-leveling of officer AMEDD personnel requires the concurrence of HQ HSC and MILPERCEN. Generally, installation commanders directing the cross-leveling of enlisted and officer personnel consider, as first priority, intra-MACOM transfer of qualified AMEDD personnel from late deploying units to early deploying units.

4 Enlisted personnel requirements for active component deploying AMEDD units are, to the extent possible, filled at installation level through the assignment of IRR personnel through the Mobilization Personnel Processing Systems (MOBPERS) and cross-leveling actions.

5 Deploying Reserve Component (RC) AMEDD units depend on IRR fill through the MOBPERS at installations and cross-leveling actions from other, later-deploying RC units for required personnel fill.

6 RC non-deployable AMEDD units come under the command and control of the gaining HSC MEDCEN/MEDDAC/Activity upon mobilization at home station (units remain under Operational Control (OPCON) to a Continental U.S. Army (CONUSA) for move from Home Station (HS) to Mobilization Station (MS).

7 During early phases of contingency and mass casualty situations, dental personnel are prepared for, and may function in, a paramedical capacity supporting medical requirements associated with mobilization.

(b) Training.

1 The Commandant, Academy of Health Sciences (AHS), is responsible for the following:

a Continued administration of the AHS to include the U.S. Army Medical and Optical School (USAMEOS), and provisions of courses for AMEDD, other Army, other Services, and foreign national personnel.

b Provision of Programs of Instruction (POI) and supporting materials to MEDDACs/MEDCENS that have mobilization training responsibilities.

c Planning at Army hospitals and other Federal and civilian institutions for training of personnel in specialties which require special environment and patient care activities.

2 Under the condition of full or total mobilization, the following education programs are suspended effective M-Day. Depending on requirements of the AMEDD, students in a program may be permitted to continue until completion.

a Scholarship programs for AMEDD officers.

b Long term civilian training and degree completion programs.

3 Refresher training for AMEDD officers who have been separated from Active Duty for more than one year is conducted by the initial unit of assignment, except for refresher training specifically provided by HSC.

4 Refresher training for enlisted personnel who have been separated from Active Duty for more than one year is conducted on-the-job by the initial unit of assignment.

5 Applicatory training for enlisted personnel as a formal phase of school training continues during a partial mobilization at those hospitals conducting such training in peacetime. Applicatory training is conducted as a formal phase of school training during a full or total mobilization, when the CDR, HSC determines such training is an essential part of adequate training for a particular Military Occupational Specialty (MOS). It is the responsibility of each commander to emphasize and ensure active supervision of on-the-job training as a means of fully qualifying an individual in the MOS.

6 Training of AMEDD officers in medical and/or military science courses is that which is absolutely essential to meet mobilization requirements.

7 AMEDD officer personnel in the following training categories are not available to local commanders in

meeting their mobilization personnel cross-leveling requirements.

a Military residents - unless Office of the Surgeon General (OTSG) approves.

b Military interns.

c AMEDD officer personnel attending long courses (over 20 weeks) in Service schools or in Medical Treatment Facilities (MTFs).

d Medical, osteopathic, dental, or veterinary students in the Army National Guard and the Army Reserve, to include the Individual Ready Reserve and Standby Reserve, while attending schools of medicine, osteopathy, dentistry or veterinary medicine.

8 The formal training of nurse anesthetists and operating room nurses continues during mobilization. Hospitals conducting such training during peacetime continue this training activity during mobilization. Also, formal training for certification of occupational therapists and the registration of dietitians continues.

9 Priority in individual training is given to individuals in medical units alerted for overseas deployment or to individuals to be assigned directly to overseas commands.

10 Priority in refresher training is given to enlisted specialists being trained as replacements for combat losses.

(c) Installations and Facilities.

1 Maximum use of existing facilities is planned.

2 Currently approved projects, not substantially started, are reviewed by sponsoring agencies to eliminate all construction not essential to the war effort.

3 Rehabilitation of reactivated facilities conforms to detailed standards developed by the Chief of Engineers to meet basic operational needs ensuring the most economical use of available resources.

4 The Commander, HSC, directs activations of Intra-Service Support agreements (ISSA) in effect between MEDCEN/MEDDAC and installation commanders governing the use of nonmedical buildings, transportation, maintenance, law

enforcement/security, and other functions required to support the fixed base AMEDD expansion mission.

5 Installation commanders continue to provide base operations support to HSC activities under mobilization conditions in much the same manner as in peacetime. In this connection, the location of Non-Industrial Facilities (NIFs) requiring base operations support is communicated to the installation staff by the HSC activity. Emphasis is placed during mobilization on contracting integral support (laundry, food service, etc.) to the maximum extent feasible.

6 Requests for additions or deletions of NIFs for convalescent care or staff housing is communicated by the appropriate HSC activity to the installation. NIFs are not located more than 50 miles distant from parent activity without prior approval of HSC.

(d) Logistics.

1 Class VIII (medical) materiel remains the management responsibility of OTSG during mobilization.

2 Class VIII POMCUS Unit Residual Equipment (PURE) left by deploying units is under the custodial responsibility of the Installation Medical Supply Account (IMSA). FORSCOM directs the redistribution of Class VIII PURE assets in

accordance with fill priorities. Assets excess to FORSCOM requirements are reported to the U.S. Army Medical Materiel Agency.

3 Medical emergency supply requisitions with standard national stock numbers are routed through the Defense Automated Addressing System (DAAS) to the Defense Personnel Support Center (DPSC).

4 The provision of Class VIII preplanned supply is the responsibility of OTSG, and is provided to the deployed forces.

5 Mobilization expansion planning for medical materiel is based on M+3 months level of activity.

e Evacuation.

1 The most expeditious means of evacuation, consistent with established medical procedures, is used for evacuation of patients.

2 As a general rule, within CONUS the U.S. Air Force provides aeromedical evacuation for distances beyond 100 miles of the aeromedical staging facility, and the destination hospital provides for evacuation, normally surface, for distances within 100 miles of the aeromedical staging facility.

3 MEDCEN/MEDDAC commanders provide projected patient evacuation vehicle requirements, such as ambulance bus conversion and EMS vehicles, to the installation commander for inclusion on installation Mobilization Table of Distribution and Allowances (MOBTDA). The installation further identifies these vehicle requirements to Army Materiel Command National Inventory Control Point for post-mobilization procurement. Installation planning considers local rental of vehicles to satisfy MEDCEN/MEDDAC patient movement requirements until post-mobilization procurement actions can be effected.

(f) Veterinary Support.

1 Uniform use of veterinary services throughout the Department of Defense continues upon mobilization.

2 Local Deputies for Veterinary Activities evaluate their veterinary logistical requirements during mobilization. They determine the detailed logistical requirements by meeting with the mobilization planners at each military installation for which they are responsible. On Army installations, the Deputy for Veterinary Activities generally consults the mobilization planners in the Directorate of Plans, Operations, Training and Security. On Air Force, Navy and Marine installations, mobilization planning may be done

separately by tenant commanders, or the Directors of Administrative Services.

3 The following veterinary logistics areas are addressed in the local mobilization plans.

a Transportation.

b Personnel.

c Equipment.

d Supplies.

e Communications.

f Buildings.

g Support Services.

(g) Research and Development.

1 Maximum in-service research effort is directed to those areas of immediate concern to the combat effort (basic applied research).

2 Contracts for research efforts are adjusted during the initial stages of mobilization to compensate for any and all diminishing in-service potential.

3 Training in areas of research continues at maximum capability commensurate with the availability of personnel.

4 Increased emphasis is directed toward obtaining field data in the following areas:

- a Communicable diseases/immunization.
- b Psychological factors.
- c Wounds produced by newly introduced weapons.
- d Medical fitness standards.
- e Medical materiel requirements.
- f Epidemiology assessment and infectious disease control.
- g Mass casualty management.

h Nuclear, biological, chemical
defense assessment.

i Health hazards assessment.

j Studies on self care.

(h) Blood Program.

1 Designated U.S. Army Medical Treatment Facilities (MTFs) have a mobilization mission to operate blood donor centers. The primary blood products required are red cells, fresh frozen plasma and platelets.

2 All blood collections by the Army are limited to members of the uniformed services, their family members and civilian personnel serving at military installations.

3 All blood groups and types are drawn, processed and shipped to meet assigned quotas.

4 MEDCEN/MEDDAC blood donor centers ship processed blood by commercial air to arrive no older than 72 hours at designated destinations.

5 MEDCEN/MEDDAC where blood donor centers are NOT operated ship "unprocessed" whole blood to the Blood Bank Center at Fort Hood or to the Blood Bank Center at Fort Knox, as directed, for processing and consolidation of shipments to designated destinations. This type of blood is shipped to arrive no older than 24 hours at one of the reference blood bank centers.

5. Navy.

a. Purpose. To describe how the Navy Medical Department supports mobilization efforts.

b. Discussion.

(1) Concept. Approved planning scenarios specify a war of high intensity and relatively short duration, during which only minimal replacements would be available to combat units from nonmedical sources. The first priority of the Navy Medical Department is to maintain the manpower of the operational forces by prevention of Disease and Nonbattle Injury (DNBI) and by treatment of casualties to rapidly return to duty. The requirements for less demanding contingencies will be supported by the execution of parts of, or modifications to, major plans. Naval Warfare Publication (NWP-6) provides overall Navy medical support doctrine. Contingency requirements predicted for a major war necessitate the deployment of a large

number of medical department personnel from CONUS medical treatment facilities to the combat theater and other overseas areas. Medical augmentation of the operating forces will occur prior to or during the first phase of mobilization and prior to the availability of Naval Reserve assets. Active duty personnel will augment Fleet and Fleet Marine Force (FMF) units on their deployment to prospective combat theaters or other overseas areas. In the second phase, after the mobilization of reserves, active duty and reserve personnel will deploy to expeditionary and prepositioned medical components and to afloat medical facilities. In many cases only a caretaker staff will be retained in CONUS Naval Hospitals, Dental Centers, and other Naval Medical Command (NAVMEDCOM) activities. In the last phase, CONUS medical facilities will be staffed by remaining active duty personnel, civilian employees, Naval Reserve, retired personnel, and volunteers. The Navy medical system in the Continental United States (CONUS) is the mobilization resource base which exists to provide the resources and training to support the Theater of Operations and Overseas Non-Theater Areas, to provide medical/dental care for casualties returning from the theater of operations, and to provide medical/dental care for active duty personnel, their dependents and other DoD beneficiaries as resources permit. This system consists of Military Treatment Facilities (MTFs), Veterans Administration (VA) Hospitals, and civilian hospitals affiliated under the National Disaster Medical System (NDMS).

Operation Plan Medical Support Requirements are based upon a combination of the existence rules and the workload-based needs that are determined by the Joint Operations and Planning System (JOPS) III Medical Planning Module (MPM). The MPM is designed to calculate scenario-dependent hospital-based medical requirements using the patient care and evacuation policy factors. Service headquarters planners use the same methodology to determine medical requirements as that used by operational commanders. Specific military manpower planning criteria are contained in Appendices A and B of the Navy Contingency Mobilization Plan (NCMP) and OPNAVINST 1000.16F dated 12 August 1986. Specific scenarios to be utilized in the Program Objective Memorandum (POM) process are promulgated as part of the Defense Guidance.

Navy Mobilization Plans and Resources guidance in wartime directs that only those active duty patients who will return to duty in less than 60 days will be retained in CONUS DoD facilities. Those requiring longer hospitalization or convalescence will be transferred to facilities of the Veteran's Administration (VA) or the National Disaster Medical System (NDMS). This guidance also requires that by mid-FY 87 all CONUS Navy Medical Department treatment facilities be capable of operating at their wartime expansion capacity to support projected numbers of returning casualties. To comply with this guidance, and to support the concept of mobilization described above, the Navy Medical Department must prepare and maintain plans for operation

of its medical treatment facilities at four levels of activity: (a) Operation of Navy Medical Department facilities in a cadre status--only caretaker staff are retained until reservists and volunteers can resume a higher tempo of operations; (b) Operation of medical facilities to provide emergency care to active duty personnel only; (c) Operation of hospitals at peacetime operating capabilities; and (d) Operation of hospitals at expanded bed capabilities.

(2) Mobilization Plan. Medical Department command actions required to support each phase of naval mobilization are identified in the following subparagraphs. Additional planning details are available in the Naval Medical Command (NAVMEDCOM) Logistics Support and Mobilization Plan (LSMP).

(a) Initial surge phase: C-day action*

1 Active duty assets from CONUS medical facilities are assigned to bring Fleet, FMF, and other deploying units to full operational manning levels.

2 CONUS treatment facilities begin to decrease the inpatient census to only active duty personnel in order to free additional medical personnel for deployment.

*C-day: The unnamed day on which a deployment operation commences or is to commence (JCS Pub 1).

3 Active duty personnel assigned to overseas Navy Medical Department facilities remain in place and those in the theater of operations are augmented by active duty personnel to bring their facilities to full expanded operational bed capacity.

(b) Surge phase: M-day actions:**

1 Selected reservists are assigned to complete operational manning of the Fleet, FMF, and other deploying units.

2 Selected reservists augment headquarters and medical logistics support units to support initial surge and rapid buildup stages. Also, selected reservists are assigned to some CONUS Navy MTFs to bring them up to a pre-determined operating level, as delineated in the Logistics Support and Mobilization Plan (LSMP).

3 Training for basic skills is accelerated to provide replacement personnel. Training is conducted at those sites determined by Health Sciences Education and Training Command (HSETC) and Commander, Naval Reserve Forces (COMNAVRESFOR).

**M-Day: The term used to designate the day on which mobilization is to begin (JCS Pub 1).

(c) Rapid Buildup phase: M+15 Days actions:

1 Active duty and selected reserve Navy Medical Department personnel deploy to prepositioned Advanced Base Functional Components (ABFCs), fleet hospitals, and hospital ship(s).

2 Naval Reserve and retired personnel begin to expand the CONUS medical/dental capability to provide medical support for both evacuees from the combat theater and mobilized Navy and Marine Corps Reserve units/personnel.

3 The NDMS is activated and the VA hospital system is alerted in preparation for casualty reception.

(d) Full mobilization stage: M+60 Days actions:

1 Expansion of CONUS medical treatment facilities is complete.

2 HSETC expands training facilities to meet phased requirements for trained personnel as stated in the LSMP.

c. Manpower. The method to determine medical manpower requirements to support mobilization is detailed in the NCMP.

(1) Numbers of Current On Board Personnel fluctuate throughout the course of the fiscal year due to changes in the Navy Manning Plan. Therefore, real-time active duty capabilities of all activities under NAVMEDCOM claimancy (Claimant 18) are available from the cognizant Manning Control Authority: Commander in Chief, U.S. Atlantic Fleet (CINCLANTFLT); Commander in Chief, U.S. Pacific Fleet (CINCPACFLT); and Commander, Naval Military Personnel Command (COMNAVMILPERSCOM). Real-time capabilities of Naval Reserve assets are available from the Naval Reserve Personnel Center (NRPC).

(2) Medical Augmentees. The COMNAVMEDCOM determines the origin of medical augmentees through the Medical Personnel Unit Augmentation System (MPUAS) which summarizes medical mobilization requirements and provides for the orderly assignment of active duty personnel to the operating forces in the event of crisis or hostility. This preassignment process matches personnel capabilities with unit requirements.

d. Training.

(1) The Commander, Naval Medical Command (COMNAVMEDCOM) provides for the individual and professional training of all active duty Navy Medical Department personnel. The Commanding Officer, Health Sciences Education and Training Command (HSETC) develops and maintains plans, objectives, priorities, procedures, and standards to meet education and

training requirements, and manages the execution of approved programs.

(2) The Commandant of the Marine Corps (CMC) has oversight for the administration of Field Medical Service Schools (FMSSs) and provides for the training of Navy Medical Department personnel assigned to FMF.

(3) The Commander, Naval Reserve Forces (COMNAVRESFOR) controls the training and education of all inactive Naval Reserve medical and dental personnel.

(4) The Commandant, U.S. Coast Guard, has responsibility for the training of its enlisted personnel as general duty hospital corpsmen.

(5) The Navy operates its mobilization training function utilizing the following guidance:

(a) Upon mobilization (M-Day), training and education will contribute to combat casualty care skill enhancement and be confined to essential, short-term requirements dictated by scenario.

(b) Training courses are accelerated and truncated to the maximum extent feasible to sustain the

availability of personnel to meet mobilization buildup requirements.

(c) Skill shortfalls in the active and reserve forces are filled by volunteer veterans, the direct procurement of related civilian skills, or Navy training of new accession civilians.

(d) Nonessential peacetime-only activities are disestablished at M+1 month, and associated personnel identified as available for reassignment at M+1 to M+3 months.

(e) Medical officer internship training shall continue after M-Day. Such training is accelerated to the maximum extent feasible and should emphasize emergency and trauma medicine and surgery.

(f) No personnel are programmed for military professional development education after M-Day.

(g) Personnel (except residents) attending basic specialized skill training programs continue such training under accelerated conditions until completion.

e. Medical Department Mobilization Facilities. Navy Medical Department facilities expand their capacities beginning at M-Day. Not all facilities expand, however; some constrict so

as to allow increased staffing at activities designated in the LSMP as casualty receiving treatment centers.

(1) CONUS Medical Facilities. CONUS medical activities provide medical/dental care to naval forces and other eligible beneficiaries, and represent the contingency mobilization base for the readiness training and professional development of personnel. These facilities also serve to care for returning casualties. OPNAVINST 4040.33E (series) establishes procedures whereby Commander, Naval Facilities Engineering Command (COMNAVFACENGCOM), in conjunction with the Navy Medical Department, plans for major CONUS facilities in support of specific major OPLANS of Navy component commanders. This planning is reflected in the Navy Medical Department Logistics Support and Mobilization Plan (LSMP).

(2) CONUS Dental Facilities. Shore-based dental facilities continue to provide dental services to CONUS based Navy and Marine Corps personnel and assist in providing comprehensive (dental) care to returning casualties.

f. Logistics.

(1) The Naval Medical Command (COMNAVMEDCOM) computes Department of the Navy mobilization requirements for all medical materiel items in the Department of Defense Section of the Federal Supply Catalog. These requirements consist of all

medical materiel in the quantities necessary to establish, maintain, and expand existing medical and dental facilities on a worldwide basis.

(2) The Naval Medical Materiel Support Command (NAVMEDMATSUPPCOM), under the direction of the Commander, Naval Medical Command, projects the mobilization materiel requirements for all Navy and Marine Corps medical and dental units based upon assigned missions; develops and maintains Authorized Medical Allowance Lists (AMALs) and Authorized Dental Allowance Lists (ADALs) for the operating forces; directs the initial outfitting of the units of the operating forces; and provides Navy input for management of the medical and dental section of the Federal Supply Catalog (item entry, use, migration, etc.).

(3) The Fleet Materiel Support Office (FLEMATSUPPOFF or FMSO), with technical guidance from the NAVMEDMATSUPPCOM, manages the demand-based medical segment of the Navy Retail Supply System.

(4) War Reserve Materiel. Coordinated Navy and Marine Corps medical logistics planning is accomplished at all organizational levels to ensure sustainability of naval forces, as well as the availability and effective employment of Medical Department resources. The NAVMEDMATSUPPCOM computes the total medical and dental War Reserve Materiel Requirements (WRMR) based on the Defense Guidance (DG), Navy Capabilities and

Mobilization Plan (NCMP), Marine Corps Capabilities Plan (MCP), CNO planning guidance, DLA guidance, and other directives.

(a) Other War Reserve Materiel Requirements (OWRMR). War Reserve Materiel Stocks (WRMS) consist of assets to satisfy these requirements. War reserve materiel stocks are maintained at levels designated to meet specific requirements during periods defined in the NCMP.

(b) Prepositioned War Reserve Materiel Requirement (PWRMR):

1 PWRMR is that portion of the total war reserve materiel requirement which approved defense guidance dictates be reserved and prepositioned at or near the point of planned use or issue to the user prior to hostilities, to reduce reaction time and to assure timely support of a specific force or project until replenishment can be effected.

2 Navy War Reserve Projects (NAVWARPs). NAVWARPs are established by CNO and constitute the PWRMR program. Each provides authorization for materiel to be acquired and retained in support of specific contingency plans.

(5) Resupply System. Materiel requisitions are submitted through local naval support activities in Military Standard Requisitioning and Issue Procedure (MILSTRIP) format.

COMNAVMEDCOM provides fiscal resources for its activities' requisitions. Materiel requisitions are filled by the appropriate inventory managers upon receipt of MILSTRIP requisitions; local naval support activities assist in identification of appropriate commodity managers.

(a) COMNAVMEDCOM assists commands in identifying the total supply and equipment requirements necessary to support maximum facility capacity (wartime casualties) for 60 days. Upon identification of required supplies, the Naval Retail Supply Depot System is activated on a requisition demand basis to achieve levels directed by COMNAVMEDCOM.

(b) Unless otherwise directed, the frequency of shipment of resupply items is in 10-day intervals.

g. Blood Program. The Navy Medical Department maintains the Navy Blood Program (NBP) which provides blood products needed by patients receiving care in Navy medical treatment facilities. The NBP is a regionally organized system of blood donor centers centrally managed by the Commander, Naval Medical Command. The NBP expands its blood collection, processing, and shipping operations in accordance with the planning guidance contained in the NAVMEDCOM LSMP. The NBP expands unilaterally in response to an emergency within the Navy Department, or it expands in concert with the blood programs of other military departments at the request of, and under the coordination of the

Armed Services Blood Program Office (ASBPO), Washington, DC. The ASBPO coordinates the blood programs for the three military departments and maintains contracts with civilian blood agencies to ensure blood product support, under all degrees of emergency conditions, when blood product requirements exceed the organic capabilities of the military departments.

h. Research and Development. Medical support of an expanded contingency force requires medical technology and information support emanating from Navy medical Research, Development, Testing and Evaluation (RDT&E) programs. Thus, selected (but minimal) manpower are retained to provide some essential research and development program stability after M-Day.

(1) Upon mobilization, naval medical research and development programs are expanded, reduced or terminated.

(2) Research and development efforts that are likely to field a near-term product having significant beneficial impact on operations continue; others are discontinued.

(3) There are no new assignments of military or civilian personnel to technology base programs after M-Day unless there is strong indication of a long-term conflict. Civilian personnel are retained and redistributed as necessary

to execute higher priority programs. Navy, in a long-term conflict, maintains all RDT&E programs in existence on M-Day.

6. Air Force.

a. Purpose. To describe how the U.S. Air Force Medical Service supports mobilization.

b. Discussion.

(1) Concept. The Air Force War and Mobilization Plan (WMP) supports the Joint Strategic Capabilities Plan (JSCP), documents manpower force availability, provides functional planning guidance, and integrates Operations Plan (OPLAN) Time Phased Force Deployment Listing (TPFDL) requirements planning with Air Force mobilization planning. The Air Force participates in Secretary of Defense mobilization activities by having the Surgeon General serve as a member of the Defense Health Council and by providing a representative in the grade of Brigadier General (O-7) or above to the Medical Readiness Policy Advisory Committee.

(a) Medical Mobilization Requirements. Upon mobilization the Air Force Medical Service will support OPLAN execution, provide medical support to personnel recruitment and acquisition, maintain and expand its medical training role, support the residual CONUS active duty force and provide care to

returning casualties. Every medical unit is required to support wartime and/or mobility missions.

(b) Medical Support Within the CONUS.

1 Thirty-six casualty receiving hospitals (e.g., medical centers, regional hospitals, and other selected hospitals having an expansion capability of 100 beds or more) are designated to receive casualties from the theater of operations. These facilities will operate at an expanded bed capacity, and bed utilization will be directed toward acute care patients requiring short-term care (under 60 days) and for those with battlefield-unique illnesses/injuries. Other casualties will receive care from Veterans Administration hospitals or from the civilian sector through the National Disaster Medical System. CONUS medical units not designated to deploy or to receive returning casualties will continue to support the local Air Force mission, but will generally limit medical services to primary care and aeromedical/aerospace services for active duty personnel. Beneficiaries other than active duty will be provided medical care through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

2 Mobilization will increase medical demands on the local civilian community. These increases will be due to military dependents seeking care through CHAMPUS-provided services, additional numbers of eligible military

dependents, and loss of local professionals who may be subject to military service. Military pharmacies as well as administrative personnel to assist in claims processing can expect increased workloads. Additional civilian personnel, such as those working with toxic materials, can materially increase the installation workloads for routine monitoring. Use of contract services, and use of paramedical personnel, may assist in meeting some requirements.

(c) In support of mobilization the Air Force Medical Service:

1 Deploys personnel to other theaters of operation in support of the four echelon casualty care system.

2 Terminates or defers activities not essential to the war effort in order to permit the reallocation of personnel to higher priority tasks.

3 Provides Air Force and civilian personnel augmentation necessary to accomplish the Armed Services Medical Regulating Office mission as determined by the Secretary of Defense.

4 Coordinates use of Personnel Support for Contingencies (PERSCO) teams to provide personnel support to patients hospitalized within military/VA/NDMS medical facilities.

5 Deploys air transportable hospitals and air transportable clinics.

6 Establishes full capability at casualty receiving hospitals.

7 Acquires pre-identified non-industrial facilities required for expanded medical operations.

8 Assists Military Enlistment Processing Stations (MEPS) by performing required medical equipment maintenance and providing requested medical consultation or hospitalization for inductees when required.

9 Supports an aeromedical evacuation system within CONUS, between CONUS and overseas areas, and between and within overseas areas, consistent with assigned resources by providing fixed and mobile aeromedical staging units, aeromedical evacuation command and control centers and elements and medical crew members.

10 Establishes aeromedical staging units in support of military/VA/NDMS medical facilities at selected CONUS aerial ports of debarkation. These units will provide patient reception and evacuation and serve as holding units for interface with domestic evacuation.

11 Establishes blood transshipment centers in the theater of operations; a system of CONUS blood donor centers for the collection of whole blood and blood components at military installations; and capability to receive, store, reclassify, type and consolidate blood products for shipment at the Armed Services Whole Blood Processing Laboratories.

12 Identifies and recommends enactment of those emergency authorities necessary to implement mobilization plans through the Joint Chiefs of Staff to the Office of the Assistant Secretary of Defense (Health Affairs).

13 Assists in mobilization processing through: identifying requirements for and processing of requests for spectacles/protective mask inserts; screening for temporary or permanent medical disqualifications; providing dental panorex, as required; ensuring dental classification A; providing immunization needs; screening for Acquired Immune Deficiency Syndrome; and identifying requirements for and processing of hearing aid requests.

14 The Dental Service maintains flying personnel in Class A. Other critical personnel subject to sudden deployment should be free of dental conditions that could exacerbate within a relatively short time.

15 Units located where dental facilities of their own service are not readily available are provided dental care by other services or civilian resources.

(d) Prisoners of War. Hospitalization of Prisoners of War will be in accordance with the provisions of the Geneva Convention. The U.S. Army is particularly responsible for ensuring medical care for Prisoners of War.

(2) Manpower.

(a) The Air Force Surgeon General is programming resources to maintain or achieve aggregate manning of not less than 90 percent of the programmed military manpower structure by FY 90. Programmed manning is measured separately for the active, reserve, and national guard programs.

(b) On M-Day, the demand for military manpower is raised to reflect the activation of additional force structure. The Selected Reserve is mobilized at peacetime strength and becomes part of the active force structure. Early deploying units (active and reserve) are raised to wartime manning levels.

(c) Air Reserve Forces: Upon mobilization, Air Reserve Forces medical units and elements are used by Major

Command (MAJCOM) surgeons to augment CONUS medical treatment facilities and to support theater medical requirements.

(d) Civilian Manpower: On M-Day, the only component of civilian manpower supply is the peacetime work force. After M-Day, new hires and conversions of part-time and intermittent employees provide additional civilian manpower to allocate to the mobilization mission.

(e) Augmentation Forces: Active duty and Air Reserve Forces (ARF) will be deployed to staff wartime units and assemblages at all levels of care. The magnitude of augmentation will be consistent with theater OPLANS.

(f) Pre-allocated medical mobilization augmentees report to their designated place of duty upon request of the MAJCOM.

(g) Priority of Allocation: The Time Phased Force Deployment List (TPFDL) serves as the source document for manning priorities in a theater of operations. Priorities established within the USAF Program Document - Bases, Units and Priorities (PD), are used for war and mobilization personnel assignments.

(h) The Air Force Surgeon General will determine priorities when insufficient personnel are available to satisfy requirements.

(i) Fillers and replacement personnel. Priority for manning is designated in Annex F to the War Mobilization Plan - I.

(3) Training.

(a) Medical training not related to wartime requirements will be terminated on D-Day. Concurrently, the remaining training will be continued or accelerated as appropriate to meet wartime needs. The Air Training Command and Air Force Systems Command Surgeons will determine which medical training is terminated, continued, or accelerated.

(b) Applicatory training for enlisted personnel as a formal phase of school training continues during a partial mobilization at those hospitals conducting such training in peacetime. Applicatory training is conducted as a formal phase of school training during a full or total mobilization, when determined essential for a particular specialty. Each commander ensures active supervision of on-the-job training to fully qualify an individual in the appropriate Air Force Specialty Code (AFSC).

(c) Air Force medical officers will continue in medical and/or military science courses if the training is absolutely essential to meet mobilization requirements.

(d) Medical and Dental Intern Programs are one year in length and approved by the Accreditation Council for Graduate Medical Education. Officers participating in medical or dental internships on M-Day will continue in such training until completion.

(e) Residency training for medical and dental officers is restricted to that necessary to produce those specialists for which a critical need exists.

(f) The formal training of nurse anesthetists and operating room nurses will continue during mobilization. Hospitals conducting such training will continue during mobilization. Also, formal training for certification of occupational therapists and the registration of dietitians will continue.

(g) Priority in individual training will be given to individuals in medical units alerted for overseas deployment or to individuals to be assigned directly to overseas commands.

(h) Priority in refresher training will be given to enlisted specialists being trained as replacements for combat losses.

(4) Hospital Facilities.

(a) Thirty-six casualty treatment hospitals, as designated by the Air Force Surgeon General, will operate at an expanded bed capacity during wartime. Bed space within these medical facilities will be directed toward acute care patients. Air Force casualty treatment hospitals are prepared to manage patients from all the armed services.

(b) Maximum use of existing facilities will be made. Expanded bed capacity is obtained by compressing peacetime spacing between beds from 120 square feet to 72 square feet per bed.

(c) Currently approved projects, not substantially started, will be reviewed by sponsoring agencies to eliminate all construction, not essential to the war effort. Design and construction methods will be changed to favor the use of materials most plentiful in order to conflict least with production of combat materiel, to speed up construction, and to conserve manpower, materials, and equipment.

(d) Maximum use will be made of all available local resources, including labor, materials, plant and contractor organizations in order to conserve military resources required for the war effort.

(e) Mobilization of CONUS bases is met through existing active installations, supplemented, as necessary, by facility acquisition or leasing or reactivation of existing facilities.

(f) Non-DoD non-industrial facilities, after coordination with the Regional Federal Emergency Management Agency through the Department of the Air Force and the Defense Logistics Agency, may be used as convalescent care facilities if they can be economically staffed and operated.

(g) VA and NDMS coordinating centers are casualty reception areas and will provide for patient transport within their local areas. These coordinating centers will conduct:

1 Joint operations in education, communications, transportation, patient sorting and processing, acute medical care, data management, supply, legal reimbursement, community relations, and public information requirements.

2 Reception, sorting, emergency care at airport arrival point.

3 Transportation to receiving hospital from airport arrival point.

4 Administrative responsibilities, including patient accountability and personnel reporting actions.

5 Daily submission of bed availability reports to the Armed Services Medical Regulating Office (ASMRO).

6 Maintenance of patient locator and information systems.

7 Provisions for military personnel management.

8 Maintenance of communications between area participants, including secure data communications.

9 Liaison with local airports for use of facilities as patient reception areas; medical materiel storage; use of airport communications system; patient staging, redistribution, and overnight holding of patients, including food service requirements.

(5) Logistics.

(a) Wartime support for USAF and Air Reserve Forces is provided through the utilization of peacetime assets, plus War Reserve Materiel (WRM). On-hand base peacetime operating stocks are used to support WRM/War Consumables Distribution Objectives (WCDO) requirements when insufficient WRM assets are available. WRM is prepositioned at or near the base of intended use or airlifted to the employment bases prior to, concurrently with, or following the deploying forces. To prevent unnecessary duplication of assets and misuse of critical airlift, a WRM control reporting system is in-place.

(b) AFR 400-24 (WRM policy) dated 24 October 1983, establishes the basic policies and responsibilities for the authorization, stockage objectives, location, distribution, accounting, preservation, and management of equipment and supplies in the WRM program. MAJCOM and Separate Operating Agency (SOA) Surgeons plan and program for procurement of War Reserve Materiel (WRM) as specified by the guidance in AFR 400-24 and AFM 67-1, Vol V, Chapter 15, dated 30 January 1983, as revised.

(c) Medical equipment repair support is provided by each medical facility as augmented by available medical equipment repair center personnel.

(d) Medical emergency supply requisitions with standard national stock numbers are routed through the Defense Automated Addressing System (DAAS) to the Defense Personnel Support Center (DPSC) for direct shipment to the requesting facility or unit.

(e) Resources, including Prepositioned War Reserve Stocks (PWRS), are programmed for the wartime medical structure capable of supporting the established medical evacuation policy.

(f) Medical assets needed during the period before they can be sealifted to and made operational in those theaters, are preconfigured and prepositioned in Europe, Southwest Asia, Korea, and other strategic locations.

(6) Patient Evacuation/Medical Regulating.

(a) The most expeditious means of evacuation consistent with established medical procedures, will be used for evacuation of patients.

(b) As a general rule, within CONUS the U.S. Air Force provides aeromedical evacuation for distances beyond 100 miles of the aeromedical staging facility and the destination hospital provides for evacuation, normally surface, for distances within 100 miles of the aeromedical staging facility.

(c) Patient Evacuation System: The Air Force operates an Aeromedical Evacuation System (AES) composed of fixed and mobile aeromedical staging units, aeromedical evacuation command and control centers, management branches, and elements and medical crew members within and from unified and specified command areas.

Aeromedical Staging Units/Facilities are established by HQ MAC/SG at selected CONUS ports of debarkation. These units provide patient reception and evacuation and serve as holding areas for interface with domestic evacuation. The capacity of these units should be expandable to respond to escalating evacuation requirements.

(d) VA/NDMS Coordinating Facilities and Casualty Receiving Hospitals provide patient evacuation vehicle requirements, such as ambulance, bus conversion, EMS vehicles, etc. to the installation commander. Installations should consider local rental of vehicles to satisfy patient movement requirements until post-mobilization procurement actions can be effected.

(e) When circumstances preclude more detailed reporting, patients requiring hospitalization are regulated by ASMRO in the following categories:

1 Medical (MIM)

III-B-60

2 Psychiatric (QPG)

3 General Surgery (SGS) includes all surgical needs unless otherwise specified as well as all patients who, regardless of diagnosis, can be cared for by a general surgeon. Other surgical categories should be used only when specialist care is absolutely required when considering the large number of patients requiring care.

4 Burns (SBN). Includes only those patients who require specialized, organized burn centers.

5 Neurosurgery (SNS)

6 Orthopedics (SOR)

7 Urology (SUR)

8 Oral/Maxillo-Facial (SMF)

9 Ophthalmology (SOP)

10 Thoracic (STH)

11 Spinal Cord (SCI)

(f) Returning casualties who require hospitalization in excess of 60 days, domiciliary care, or require specialized care beyond the capability of the military services (i.e., spinal cord injuries) are regulated to Veterans Administration or National Disaster Medical System facilities.

(g) Reporting in only eleven categories begins when and if the numbers of patients returning to CONUS from overseas exceed that which can be managed using the detailed, individualized procedures. When circumstances permit, more detailed reporting will resume, with the goal of returning to peacetime procedures as soon as possible.

1 This reporting system involves two separate tasks: the reporting of patients and their needs; and, the reporting of CONUS hospitals' capabilities. Both reports use the same eleven categories. Regulators take action based upon reported data by matching requirements with capabilities and advising patient-originating facilities of appropriate destination hospitals. In the process, regulators strive to balance workload among available medical facilities and otherwise act to enhance the most efficient use of all medical resources.

2 CONUS hospitals report medical capabilities using the number of operating beds (beds which are staffed, equipped, and otherwise fully available for patient

use) in each of the eleven categories. Reports are submitted daily by single subject message as of 2400 hours local time directly to ASMRO, with an information copy to the MAJCOM/SG. MAJCOMs submit a consolidated MAJCOM bed status report to Headquarters Air Force Operations Center Medical Readiness Center (HQ USAF/AFOC-MRC) not later than 1200Z daily.

3 Overseas medical facilities report those patients requiring return to CONUS to the Armed Services Medical Regulating Office (ASMRO), using channels specified by the unified command surgeon Joint Medical Regulating Office (JMRO). Data provided by each originating facility identify only the number of patients in each of the eleven categories to be transferred.

(7) Environmental Health. Provisions exist for a system of collection, evaluation, and dissemination of information pertaining to medical findings and remedial actions of significance concerning the health and well-being of the Armed Forces and the civilian population. This information is provided to the Surgeons General of the other Military Departments.

(8) Biotechnology Research and Development:

(a) Maximum research efforts are directed to completion of items urgently needed for Air Force Combat Operations and development of medical procedures and equipment

to provide improved care and patient management in the aeromedical airlift system.

(b) Contractual research efforts are expanded during initial stages of mobilization to compensate for additional workload.

(9) USAF Blood Program.

(a) The Air Force blood program provides blood products required by Air Force casualties and serves as the logistics interface for all blood product movement from CONUS to a theater of operations.

(b) CONUS Blood Program: Theater capability is insufficient to satisfy all blood product requirements. Thus, first priority is to provide products and augmentation personnel to cover theater shortfalls. Excess collecting capability, if any, may be used to support returned casualties being treated in CONUS medical treatment facilities: Because of the disparity between peacetime workload and projected wartime requirements and ready access to a large industrial base, some dated expendables required for blood collection in Table of Allowance 893, dated July 1985, are identified in quantities only sufficient to support the first 10 days of operations at maximum tasking levels. MAJCOM Surgeons must obtain resupply of these and other expendables from either the Defense Personnel Support

Center (DPSC) or local purchase sources in order to continue at the maximum operational level. Administrative supplies identified in AFR 168-3 dated August 1982 (i.e., forms, regulations, and manuals) are in sufficient quantities to support maximum operational levels for 30 days. HQ USAF requests activation of CONUS blood program activities and identifies required tasking levels through MAJCOM channels. Locations are fully operational within 72 hours of receipt of a MAJCOM activation order.

1 ASWBPLs. These facilities provide the logistics interface between CONUS blood collecting activities and Military Airlift Command (MAC) airlift for blood products required for theater contingency support. They receive, store, reclassify (perform repeat blood group and type as a final quality control procedure) and consolidate blood products for shipment. At the maximum tasking level (3,000 units per day), an ASWBPL processes one standard pallet of blood products each day. Contingency operations at these joint service facilities begins within seven days following direction of the Armed Services Blood Program Office (ASBPO).

a McGuire AFB, NJ: This location is the primary ASWBPL. It is operated in peacetime at a minimum level and maintains a no notice response capability as defined by the Director, DoD ASBPO. In contingencies, this location is augmented and operated at maximum capability of 3,000 units per day (per AFR 168-3).

b Lackland AFB, TX: This is a peacetime, inactive location which may be tasked in contingencies to accomplish an ASWBPL mission if: (1) the McGuire location becomes non-operational; and (2) theater requirements from CONUS exceed 3,000 units per day. Under these conditions, maximum facility tasking could equal that defined for the primary site. The aerial port at Kelly AFB, TX is used for originating shipments to the theater of operations.

c In the event that the ASWBPL mission cannot be accomplished at the aforementioned locations, HQ USAF designates an alternate location. This will be at any Air Force base with existing aerial port capabilities to serve as a collecting/distribution point for blood shipments.

d The Air Force Surgeon General obtains concurrence of the Assistant Secretary of Defense for Health Affairs (ASD(HA)) through the Armed Services Blood Program Office (ASBPO) prior to closing or deactivating an ASWBPL.

e Transportation of blood products from an ASWBPL at CONUS air terminals to the destination designated by the ASBPO is the responsibility of the U.S. Air Force.

2 Medical Facility Transfusion Services.

These activities are responsible for identifying supply sources for and managing their inventory of blood products to support the requirements of casualties treated in their facilities.

3 Blood Donor Centers. Large quantity

CONUS supplementation of theater blood product resources cannot be anticipated sooner than seven days after the identification of a requirement. Theater centers provide immediate response capability during this interim period as directed by the theater program manager. To provide sufficient resources, it may be necessary to process as many products (primarily as whole blood) per day as is physically possible, beginning early in a mobilization period. Every acceptable donor resource should be used including non-combatant evacuees. Potential donor availability, upon mobilization, must be evaluated in coordination with the theater program manager on a center by center basis to ensure adequate and appropriate tasking. Because of the massive activity anticipated in the early stages of a major contingency, centers are prepared to go where the potential donors are concentrated to maximize collections. Upon initiation of hostilities, it may be necessary to curtail selected centers or transfer donor activities to locations where continued operation can be expected to remain effective.

7. Marine Corps

a. Purpose. To describe how Marine Corps medical personnel and the Navy Medical Department support mobilization.

b. Discussion.

(1) Concept. The Marine Corps Capabilities Plan (MCP) and the Marine Corps Mobilization Plan (MPLAN) are the basic Marine Corps mobilization planning documents. The MCP provides amplifying information on the Fleet Marine Force (FMF) regarding the structure, composition, and employment of each Marine Amphibious Force (MAF). These forces are made available for planning in contingencies for which mobilization is authorized. The MCP complements the MPLAN by allocating reserve forces to expand Marine combat forces for both partial and full mobilization. The MPLAN sets forth policies, procedures, and responsibilities for the mobilization of the Marine Corps. The MPLAN describes the process followed to develop mobilization plans, identifies administrative procedures, and includes an extensive set of annexes addressing specific aspects of mobilization.

(2) Medical Support. The Marine Corps is unique among the four services in that it is not tasked with manning and operating permanent Medical Treatment Facilities (MTFs).

Consequently, the manning of CONUS MTFs following the mobilization of active duty medical personnel is not addressed in Marine Corps mobilization plans. The Navy is tasked with the responsibility to provide health services support, both operational and hospital-based, to the Marine Corps. During peacetime, medical personnel assigned to Marine Corps units:

(a) Provide basic sick call support to active duty personnel.

(b) Provide medical support to operations and training exercises.

(c) Develop and review medical plans in support of Marine Corps OPLANS.

(d) Maintain Marine Corps Prepositioned War Reserve (PWR) Class VIII assets.

Because of differences between peacetime and combat medical workloads, the Basic Allowance (BA) of medical personnel assigned to Marine Corps units during peacetime is significantly lower than the manning levels required to support full mobilization. Consequently, only limited operations and contingencies can be supported by BA manning levels. Medical support for a major operation would require the assignment of a large number of Navy

Medical Department personnel. Medical augmentation of the Marine Corps is coordinated by the Commander, Naval Medical Command (COMNAVMEDCOM) through the Medical Personnel Unit Augmentation System (MPAUS). These active duty Navy medical personnel are identified to augment Marine units prior to or during the first phase of mobilization and prior to the availability of Navy or Marine Corps Reserve assets. MPAUS personnel would augment FMF units on their deployment to prospective combat theaters or other overseas areas. FMF units may be provided additional medical support by Navy personnel assigned to Casualty Receiving Treatment Ships (CRTSs), Rapidly Deployable Medical Facilities (RDMFs), Navy fleet hospitals, or hospital ships. Following mobilization of the Reserves, active duty forces may be augmented by Marine Corps or Navy Reserve medical personnel or units.

(3) Mobilization Plan.

(a) Initial Surge Phase: C-Day Actions.

1 Active Duty personnel from Navy CONUS medical facilities, as identified by the MPAUS, are assigned to FMF units, bringing these units to full operational manning levels.

(b) Surge Phase: M-Day + Actions.

1 Selected Marine Corps and Navy reservists complete operational manning of the FMF.

2 Marine Corps Reserve units are mobilized to augment and reinforce the three active duty MAFs or held as a force in readiness.

c. Manpower.

(1) Numbers of Current On-Board Personnel. The Basic Allowance fluctuates throughout the fiscal year. Actual numbers of personnel on-board will determine the number of augmentation personnel requested through the cognizant Commander-In-Chief or the MPUAS.

(2) Active Duty Medical Augmentees. COMNAVMEDCOM determines the origin of medical augmentees through MPUAS which summarizes medical mobilization requirements and provides for the orderly assignment of active duty personnel to the FMF in the event of crisis or hostility. This preassignment of personnel matches capabilities with unit requirements. Additionally, MPUAS ensures that transportation can be provided through the Joint Operational Planning System for the delivery of augmentees from CONUS activities to the receiving commands.

(3) Reserve Personnel. Marine Corps Reserve personnel may provide additional medical capability by:

(a) Augmenting or reinforcing the three active MAFs.

(b) Providing organic medical support to a reserve Marine Amphibious Brigade (MAB) or, if augmentation or reinforcement of active forces is not ordered, to a fourth Division, Wing, or Force Service Support Group. (Fleet Marine Force Manual (FMFM) 4-5, Medical and Dental Support, outlines the organization and capabilities of these units.)

d. Training.

(1) COMNAVMEDCOM provides for the individual and professional training of active duty Navy Department personnel.

(2) The Commandant of the Marine Corps (CMC) has oversight for the administration of Field Medical Service Schools (FMSSs) and provides for the training of Navy Medical Department personnel assigned to the FMF.

(3) The Navy operates its mobilization training function utilizing the following guidance:

(a) Upon mobilization (M-Day), training and education will contribute to combat casualty care skill enhancement and be confined to essential short term requirements as dictated by the operational scenario.

(b) Training courses will be accelerated and abbreviated to the maximum extent feasible to sustain the availability of personnel to meet mobilization buildup requirements.

(c) Skill shortfalls in the active and reserve forces will be filled by volunteer veterans, the direct procurement of related civilian skills, or Navy training of new accession civilians.

e. Logistics.

(1) The Naval Medical Material Support Command (NAVMEDMATSUPCOM), under the direction of COMNAVMEDCOM, projects the mobilization materiel requirements for all Navy and Marine Corps medical and dental units based upon assigned missions; develops and maintains Authorized Medical Allowance Lists (AMALs) and Authorized Dental Allowance Lists (ADALs) for the FMF; directs the initial outfitting of operational units; and provides Navy/Marine Corps input for the management of the medical and dental section of the Federal Supply Catalog.

(2) War Reserve Materiel (WRM). Coordinated Navy and Marine Corps medical logistics planning is accomplished at all organizational levels to ensure sustainability of naval forces, as well as the availability and effective employment of Medical Department resources. NAVMEDMATSUPCOM computes the total

medical and dental WRM requirements based on Defense Guidance, Navy Capabilities and Mobilization Plan, Marine Corps Capabilities Plan, and other guidance.

(a) Prepositioned War Reserve Materiel Requirement (PWRMR).

1 PWRMR is that portion of the total war reserve materiel requirement that approved Defense Guidance dictates be reserved and prepositioned at or near the point of planned use or which is issued to the user prior to hostilities to reduce reaction time and ensure timely support of a specific force or project until replenishment can be effected.

2 The Medical Logistics Company, Force Service Support Group (MEDLOGCO, FSSG) is required to stock and maintain a minimum of 30 Days of Supply (DOS) of class VIII materiel in support of the MAF's worst case Marine Amphibious Brigade (MAB) OPLAN requirement. The Marine Corps supply system is required to provide Class VIII materiel in support of each MAF in accordance with the DOS established within the Defense Guidance.

3 The MEDLOGCO will issue 15 DOS of Class VIII materiel to designated units in the OPLAN Time Phased Force Deployment Document (TPFDD) and will carry the additional DOS with it, when required.

4 Sourcing. The 15 DOS allocated to designated units in the OPLAN TPFDD will be sourced from on-hand stocks of the MEDLOGCO. The remainder of the requirement will be sourced from remaining on-hand MAF held Class VIII stocks, if available, or ordered through the Marine Corps Supply System. This remaining Class VIII requirement will be provided to the MEDLOGCO.

5 Resupply. NAVMEDMATSUPCOM is responsible for coordinating and procuring additional Class VIII resupply materiel.

8. Veterans Administration (VA).

a. Purpose. To describe the VA's role as the principal support to the military health care system in the event of war or national emergency.

b. Discussion.

(1) Concept. Military hospitals within the United States have two primary responsibilities during a national emergency: (a) to provide medical care to returning military patients from overseas areas and (b) to provide medical care to the active duty force stationed in the United States. During mobilization, the DoD medical system may not have adequate health care resources to care for these military personnel. DoD

recognized the requirement to have a backup medical support system and, in December 1982, signed a Memorandum of Understanding with the Veteran's Administration (VA). This MOU provides the basis for VA to serve as the principal support medical system for DoD in the event of war or national emergency.

(2) Congressional Reports on Public Law 97-174 describe the VA missions to include serving as the primary health care backup to the Department of Defense in the event of war or declared national emergency involving the use of United States Armed Forces. To implement this law, the DoD/VA Contingency Plan makes full use of available VA medical centers, outpatient clinics, supply services, communications systems, education and other resources.

(3) In designing a system to link VA and DoD medical systems, the two agencies have focused on:

(a) Establishing primary receiving centers for the treatment of sick and wounded military personnel needing immediate care upon return from an overseas conventional war.

(b) Establishing VA secondary support centers for accepting patient transfers from the VA primary receiving centers so as to maximize the availability of VA beds; and/or

sharing of resources with the VA primary receiving center, to maximize the availability of VA beds.

(c) Establishing base support plans for VA medical facilities in proximity to military bases to provide health care services to military personnel assigned to the base.

(4) Prior to Declaration of National Emergency:

(a) Planners anticipate the possibility of a period of increasing world tensions which require partial mobilization leading to a declaration of a national emergency. During this period, the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) establishes and maintains continuous communications and liaison with the Chief Medical Director (CMD), Veterans Administration. The purpose of these communications is to develop current medical care delivery capability projections; determine possible health care delivery deficiencies in both military and VA system; initiate plans or action to resolve deficiencies; and to refine patient discharge or transfer plans for non-active duty and non-service connected VA patients.

(b) VA medical facilities located in proximity to military bases develop contingency plans to provide health care services to military forces assigned to the base in the event of war or national emergency.

(5) Declaration of National Emergency

(a) Upon declaration of a national emergency, the Secretary of Defense requests in writing that the Administrator of Veterans Affairs authorize the admission and/or treatment, on a priority basis, of active duty military personnel at VA medical facilities. Concurrent with this request, a daily liaison will be established between the Office of the Assistant Secretary of Defense (Health Affairs) and the Office of the Chief Medical Director.

(b) Upon receipt of the Secretary's request, the Administrator prescribes the priorities for treating active duty military personnel in VA medical facilities. The Secretary of Defense is notified of this decision.

(6) Operations During the National Emergency:

(a) The CMD and OASD(HA) will ensure the continual flow of critical information between the VA and DoD. This includes, as a minimum:

1 Status of military hospital's operating beds and manpower capability;

2 Status of VA medical center's operating beds and manpower capability;

3 Projections of casualty workloads;

4 Availability of medical supplies;

5 Availability of patient transportation.

(b) Both the VA and OASD(HA) maintain liaison with the Federal Emergency Management Agency, the Department of Health and Human Services, and other Government agencies, as appropriate.

9. Federal Emergency Management Agency (FEMA)

a. Purpose. To describe the role and functions of FEMA in emergency management activities prior to and during war or national emergency.

b. Discussion

(1) Concept. The Federal Emergency Management Agency is the central point of contact within the Federal Government for coordinating a wide range of emergency management activities in both peace and war. Integrated emergency management activities are undertaken in partnership with state and local authorities. Capability to meet any emergency is based essentially at the local level, with state and federal

governments providing guidance and support in all aspects of the emergency management process.

(2) Through the coordination of planning and preparedness activities and the provision of financial and technical support, FEMA provides a system that spans the full spectrum of emergencies from natural disasters to nuclear war through all levels of the government and the private sector.

(3) FEMA selected peacetime functions continuing into wartime include the following:

(a) Coordinate all mobilization preparedness functions of Federal agencies, except DoD.

(b) Develop mobilization and civil emergency planning assumptions and broad preparedness objectives.

(c) Prepare non-military plans and programs for Federal Government emergency functioning.

(d) Publish such basic Federal planning documents as "The National Plan for Emergency Preparedness," "Federal Emergency Plan D," and "Documents for Contingencies (Other Than a Plan D Situation) Which Justify Applications of Emergency Measures on a National Scale (OTD), and the Limited War Plan and Documents."

(e) Guide and coordinate Federal regional councils and State committees in emergency preparedness and emergency medical services.

(f) Coordinate materiel allocations in support of energy projects (using the amended Defense Production Act of 1950 as basic authority).

(g) Implement critical and strategic materiels policies; analyze defense materiels vulnerabilities; develop solutions including stockpiling, Defense Production Act initiatives; and establish priorities for allocating materiels in short supply.

(h) Maintain contingency plans for meeting crises arising from resource unavailability (e.g., market disruptions, transportation stoppages, and materiel shortages).

(i) Facilitate development of Federal emergency plans and procedures for claimant and resource agencies with potential military, foreign, industrial, and consumer needs; guide resource management agencies in developing allocation methods and controls.

(j) Lead US national participation in international civil preparedness activities such as those with Canada, Mexico, and the various NATO civil wartime agencies.

(k) Provide, to the non-military Federal departments, Federal agencies, state, commonwealth, territories, and local government agencies and defense supporting industries, the policy and procedures required for screening employees filling key positions who are in the Ready Reserve.

(4) Additional selected functions in mobilization or wartime include:

(a) When directed by the President, serve as an advisor to the National Security Council.

(b) Convene an emergency resources working group to be composed primarily of representatives of Cabinet agencies, to resolve major issues on national resources or to recommend possible resolutions to the President.

(c) Coordinate integration of National Defense Executive Reserve (civilian) personnel from industry, government, labor, the professions, and academic communities into executive positions in Cabinet departments and selected agencies (Department of Agriculture (DOA), Department of Commerce (DOC), Department of Defense (DoD), Department of Energy (DOE), Department of Interior (DOI), Department of Justice (DOJ), Department of Labor (DOL), Department of Transportation (DOT), and the Federal Communications Commission (FCC)).

(d) Institute resource mobilization programs complete with the necessary procedures for claimancy, allocation, system control, and enforcement.

(5) Action.

(a) The Director of FEMA reports to the President and works closely with the National Security Council, the Cabinet, and the White House staff. There are ten (10) FEMA regions, each headed by a Regional Director who reports to the FEMA Director, and is responsible for all FEMA programs in the region.

(b) In general, during a national security emergency, FEMA will alert and mobilize the industrial base manpower pools, and civil defense authorities at the National level. DoD remains responsible for management and coordination of its own resources and accomplishment of its missions, although the foregoing functions are clearly supportive of DoD.

(c) Together with the Department of Health and Human Services (DHHS), ASD(HA), and VA, FEMA is represented at the director level on the Executive Policy Group of the National Disaster Medical System. Coordination of the Civilian Reserve Air Fleet (CRAF) and medical CRAF assets for use during a military activation of the NDMS is of paramount concern to DoD.

10. Militarization and Mobilization of the
U.S. Public Health Service (USPHS) Commissioned Corps.

a. Purpose: To describe how the Commissioned Corps of the USPHS is militarized and mobilized.

b. Discussion.

(1) The U.S. Public Health Service is the major health component of the Department of Health and Human Services. Six major agencies operate within the USPHS: Alcohol, Drug Abuse, and Mental Health Administration; Centers for Disease Control; Agency for Toxic Substances and Disease Registry; Food and Drug Administration; Health Resources and Services Administration; and National Institutes of Health. Commissioned officers are assigned to each of these USPHS agencies, as well as to other Federal Agencies such as the Environmental Protection Agency, the Bureau of Prisons, the Agency for International Development, the Coast Guard, the Health Care Financing Administration and the Department of Defense. Today, there are 5,400 active duty Commissioned Corps officers and over 6,000 inactive reservists. Approximately 1,700 of the active duty officers are physicians. The remaining categories include engineers, scientists, veterinarians, dietitians, nurses, dentists, pharmacists and health service officers.

(2) Relevant Conditions: Militarization and mobilization take place when the actual or expected demand for USPHS medical manpower cannot be satisfied using both active duty Commissioned Corps members and volunteers from the inactive reserve force. The President can militarize and mobilize the USPHS Commissioned Corps in wartime or in a declared national emergency involving the national defense.

(3) Militarization and mobilization are actions that can be taken by the President under the authority of the Public Health Service Act. The first is to declare the USPHS to be a military service. This will bring Commissioned Corps members under the Uniform Code of Military Justice (UCMJ). Even after being declared a military service, the USPHS Commissioned Corps will operate as it does in peacetime under the DHHS/USPHS administrative organization.

(4) The historical precedent for the second action occurred in World War II. In 1945, President Truman issued an executive order declaring the Commissioned Corps of the U.S. Public Health Service to be a military service and a branch of the land and naval forces of the United States. The USPHS Commissioned Corps continued operating as a military service until after the end of the Korean conflict. Since that time, the Corps has functioned as a uniformed service rather than a

military service. As such, its members have not been subject to the Uniform Code of Military Justice (UCMJ).

(5) Alternative Levels of Implementation:

(a) Declare the USPHS Commissioned Corps to be a military service and thereby bring its members under the UCMJ.

(b) Declare the USPHS Commissioned Corps to be a military service and selectively mobilize members of the USPHS inactive reserve.

(c) Declare the USPHS Commissioned Corps to be a military service and mobilize all available USPHS inactive reservists.

(6) Current policies and plans call for minimum changes in the utilization of active members of the Commissioned Corps in wartime. The pool of officers available for detailing to DoD will be increased by the mobilization of inactive Commissioned Corps reservists. However, many individuals on the inactive reserve roster hold key health care positions in the civil sector and may not be available for alternative duty. OASD(HA) currently is working with the USPHS to identify specific roles for USPHS Commissioned Corps personnel and to

determine both numbers now available and numbers potentially required.

(7) Decision Process:

(a) DoD, FEMA, DHHS or other department/agency will initiate a request for Commissioned Corps health care personnel that exceeds the number readily available from the active pool and reservist volunteers.

(b) The Assistant Secretary for Health, DHHS, or other interested office will recommend to the Secretary of DHHS that the Corps be declared a military service and the Corps reservists should be mobilized.

(c) If the Secretary of Health and Human Services concurs, he/she will forward the recommendation to the White House with a draft Executive Order.

(d) The President has final approval authority over the recommendation.

(8) Implementation Process:

(a) The President will issue an Executive Order, following procedures set forth in the National Emergencies Act of 1976.

(b) The USPHS will notify inactive reservists of call-up. The USPHS will screen reservists and assign those who will be mobilized to DoD or alternative emergency duty.

(c) The USPHS will issue personnel orders.

11. Mobilization Support Programs and Services of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

a. Purpose: To describe how the Office of CHAMPUS (OCHAMPUS) expands and streamlines its operations to accommodate increases in workload during mobilization.

b. Discussion.

(1) OCHAMPUS will enact mobilization clauses in current fiscal intermediary contracts and any services delivery contracts, as appropriate, for expanded operations, personnel and systems, to allow for the increased volume of claims processing.

(2) OCHAMPUS will issue emergency sole source contracts for services, as necessary, to handle anticipated claims processing workloads.

(a) Depending on the extent of a mobilization, OCHAMPUS will terminate the at-risk contracts for services and replace these with new contracts for services, at cost.

(b) As necessary, OCHAMPUS will issue additional sole source contracts to handle excessive demands on claims processing workloads.

(3) OCHAMPUS will implement relaxed processing procedures while continuing to comply with regulatory and legal requirements.

(4) If OCHAMPUS gains approval for changes to legal and regulatory requirements.

(a) It may suspend nonavailability statement requirements.

(b) It may suspend cooperative care requirements.

(c) It may suspend deductible payments.

(d) It may suspend special care and medical review requirements.

(e) It may increase payment levels to ensure beneficiary access to care.

(5) OCHAMPUS will implement the National Disaster Medical System (NDMS) reimbursement system for active duty members receiving care in civilian (NDMS) hospitals.

(6) OCHAMPUS will issue public service announcements and distribute information packets to beneficiaries and providers concerning use of CHAMPUS.

(7) OCHAMPUS will assume the functions of the Office of CHAMPUS, Europe, if the situation demands.

(8) OCHAMPUS will increase the beneficiary and provider educational efforts to accommodate increased use of CHAMPUS.

12. Noncombatant Evacuation Operations (NEO).

a. Purpose: To describe responsibilities for noncombatant operations.

b. Discussion. NEO plans provide for the orderly evacuation of U.S. citizens and designated third country nationals from overseas at an appropriate level of emergency.

Responsibilities for noncombatant evacuation operations are as indicated below:

(1) The Secretary of State has overall responsibility for the protection and evacuation of U.S. citizens and selected aliens from overseas.

(2) The Secretary of Defense, by joint agreement with the Secretary of State, has responsibility for:

(a) Evacuation of all U.S. citizens from West Berlin and the U.S. Naval Base, Guantanamo Bay, Cuba.

(b) Preparation for and implementation of plans for the protection and evacuation of DoD-sponsored noncombatants from the Federal Republic of Germany as well as for cooperation with the Secretary of State in integrating such plans into State Department plans.

(3) The Secretary of the Department of Health and Human Services (DHHS) has responsibility for the reception, assistance, and onward movement (repatriation) of all noncombatants evacuated to CONUS under emergency conditions. The Department of the Army is the DoD executive agent for noncombatant repatriation military assistance provided to the DHHS.

(4) The Joint Chiefs of Staff are responsible for directing, coordinating, and monitoring military participation in the protection and evacuation of noncombatants.

(5) Commanders of unified commands are responsible for developing evacuation plans and for integrating their plans into those of the State Department.

(6) The current policies for conducting noncombatant evacuation operations are as follows:

(a) Normally, the principal diplomatic or consular representative in an area will request authority of the State Department to invoke an emergency evacuation plan. However, when hostilities or disturbances appear imminent, the principal U.S. diplomatic representative is authorized to invoke such elements of the plan and initiate such action as the situation warrants.

(b) Normally, the principal U.S. military commander in an area must receive authorization from the Chairman, Joint Chiefs of Staff before using any of his forces and facilities in a foreign country for protection and evacuation purposes. However, when delay would jeopardize citizens, the commander will respond as he deems militarily feasible. The military commander, when time and communications permit, acts in coordination with and under policies established by the principal U.S. diplomatic or consular representative.

(c) The State Department can normally be expected to utilize commercial transportation to the maximum and plan for minimal dependence upon military assistance.

(d) The Department of Defense will cooperate, and to the extent that is militarily feasible, will assist in carrying out protection and evacuation operations.

(7) Medical support plans for noncombatant evacuation operations are incorporated into major command plans. DoD patients who are noncombatants will be regulated through ASMRO and evacuated using peacetime procedures. Once in the Continental United States, responsibility for these patients will shift to the Secretary, DHHS. However, DoD patients regulated and evacuated by military means to a military hospital, will be handled as other DoD patients within the United States. For instance, if the Naval Hospital, San Diego, is accepting only active duty patients, a DoD dependent regulated to San Diego would be placed in a civilian hospital in the San Diego area by personnel from the Naval Hospital, San Diego.

(8) DHHS has a plan for the reception and onward movement of returning noncombatants, including patients. The plan calls for utilization of Federal, state, and local resources. While the DHHS has the planning responsibility, it is incumbent upon the individual states to carry out provisions of the plans. The USPHS will arrange for medical teams at points of entry to provide screening necessary for alien de-

pendents of U.S. citizens and for U.S. citizens who appear to have quarantinable diseases. The USPHS also assists individual states in developing plans for providing medical assistance, ranging from first aid to extensive medical treatment. This includes transportation to medical facilities. In emergency situations, the National Disaster Medical System will supplement state and local resources.

13. Enemy Prisoner of War (EPW) and Internal Control

a. Purpose: To describe current procedures for medical treatment to enemy prisoners of war within CONUS.

b. Discussion.

(1) As the Executive Agent for DoD in matters related to EPWs, the Department of the Army has established the following planning factors:

(a) EPWs/internees will receive treatment within EPW/Internment Camps whenever possible. Only in exceptional cases will EPW/internees be brought or admitted to CONUS medical treatment facilities (MTFs) external to EPW/Internal Camps.

(b) It is current policy to bring EPWs to the United States. The number of EPW and interned personnel expected to receive health care within CONUS installations and

activities has not been clearly established. EPWs requiring treatment in medical facilities other than established EPW/Internment Camp medical facilities will be transferred in custody of Forces Command (FORSCOM) Military Police. The Health Services Command Security Officer, in coordination with FORSCOM, will determine custody and control procedures necessary for FORSCOM EPW Security Personnel to provide for security of EPW/internees while they are patients outside of EPW/Internment Camp medical facilities. As soon as it is medically possible, EPW/internees will be returned to an EPW Camp medical facility for continued treatment.

14. Notification Procedures When Canadian Personnel are Hospitalized in U.S. Military Medical Treatment Facilities

a. Purpose: To discuss current patient accountability procedures for Canadian Forces personnel hospitalized in CONUS military medical treatment facility.

b. Discussion: When Canadian Forces personnel are admitted to and discharged from U.S. armed forces medical treatment facilities in the continental United States, the treatment facility will furnish appropriate notification to the Canadian Joint Staff in Washington, D.C. This notification will take the form of copies or extracts of Admission and Disposition reports, or lists which are normally prepared for all patients.